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THE

TORONTO, APRIL, 1941

# CANADIAN HOSPITAL

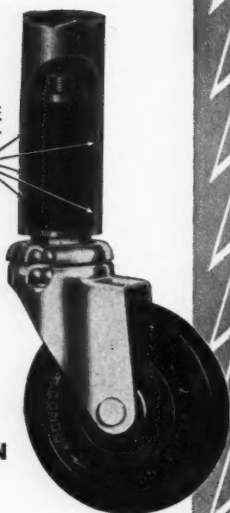


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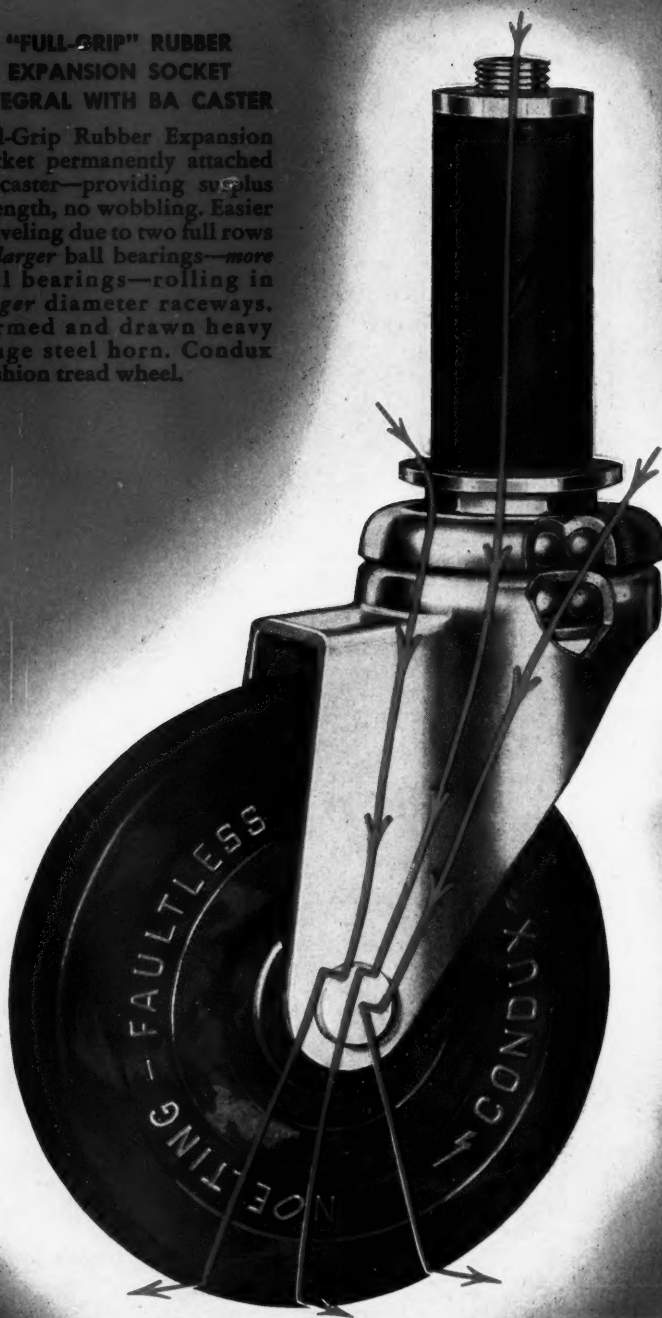
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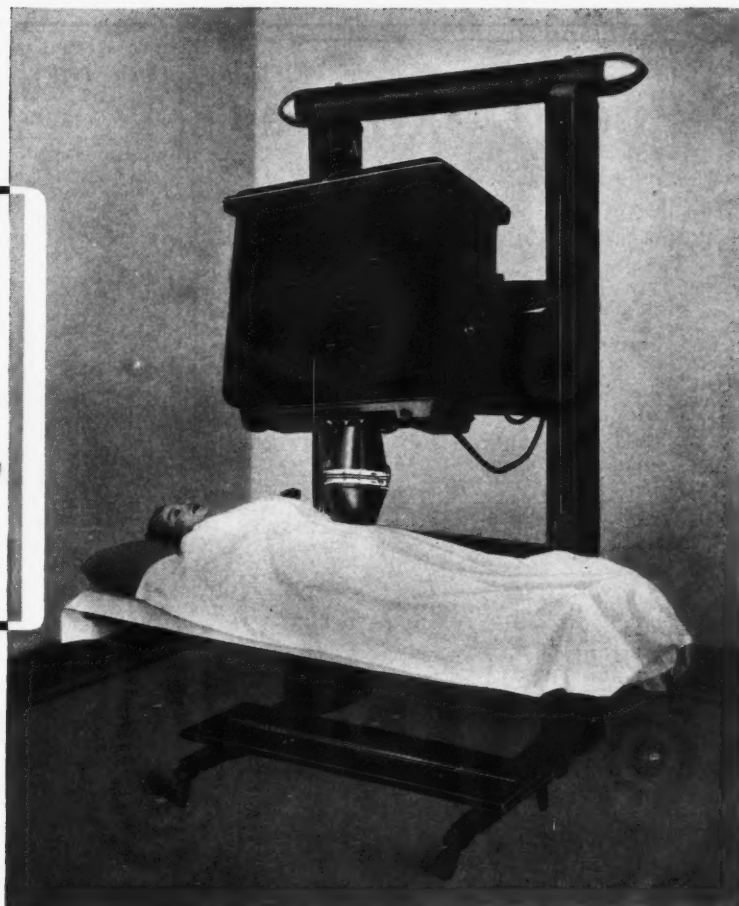


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# "The Canadian Hospital"

Official Journal of the

Canadian Hospital Council

Vol. 18

APRIL, 1941

No. 4

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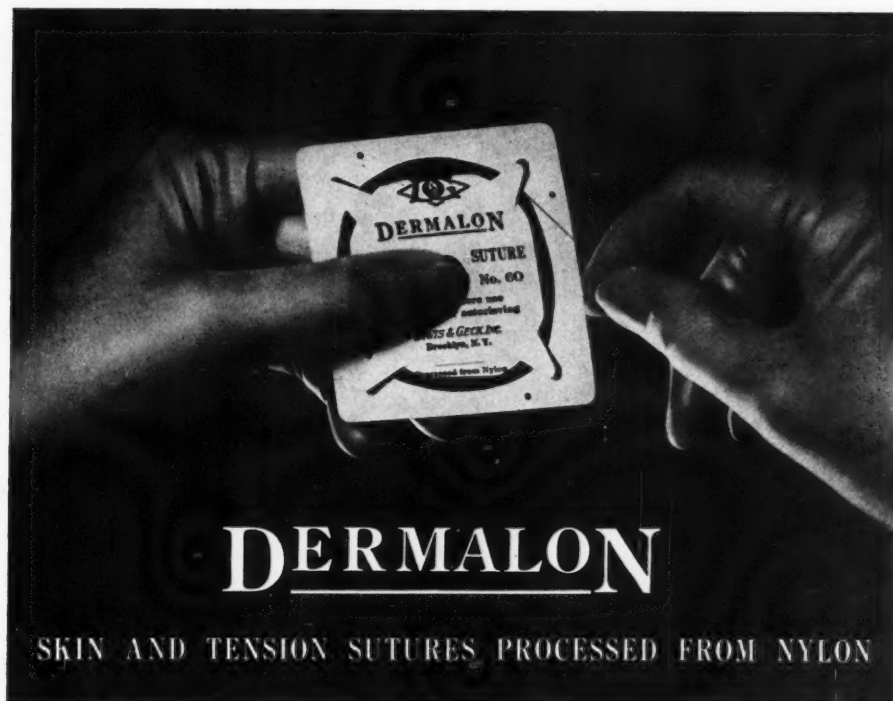
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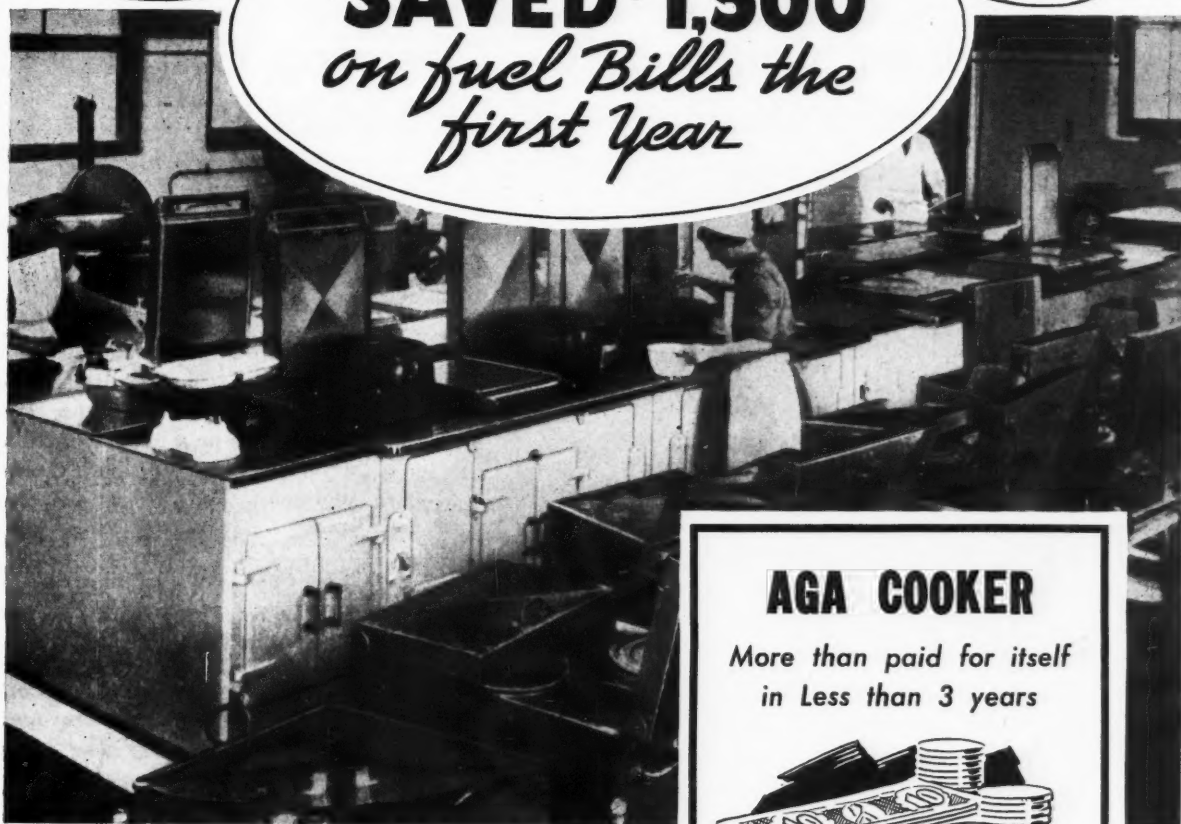
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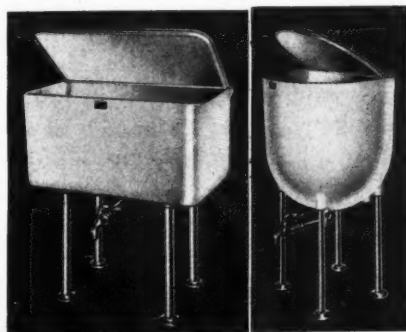
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## CANNED FOODS AS SOURCES OF THE ESSENTIAL NUTRIENTS

● Early in this century, the existence of "accessory food factors"—the vitamins—was demonstrated by animal experiments (1, 2). Since that time, building upon information established by earlier investigators regarding the calorie, protein, and mineral needs of man, contemporary workers have developed a practical and fairly complete working knowledge of nutrition. At the present time, the fundamental human dietary requirements are considered in terms of some thirty substances of known chemical composition plus a number of factors whose chemical natures still await determination (3). Likewise, the dietary values of foods also may be discussed in terms of these same essential nutrients.

Viewed from a physiological basis, nutritional failures appear to be conditioned either by consumption of a diet deficient with respect to certain of the essential food factors or to altered processes in metabolism which prevent the efficient absorption and utilization of foods (1). Failures of the latter type can be corrected only by elimination of the defects in metabolism, or by administration of nutrients by routes which permit utilization. However, the vast majority of nutritional failures are associated with the consumption of diets deficient with respect to essential food factors. In the following quotation, the facts regarding malnutrition resulting from faulty diet are concisely stated (1):

"Three facts concerning nutritive failure are becoming increasingly obvious; first, that it

does not come solely from lack of vitamins but from deficiency of proteins and minerals as well; in certain of the lower animals, it comes even from lack of fats; second, that in America it is seldom complete; and third, that it is not, as a rule, the expression of a single nutritive fault. More often it is partial in extent and multiple in nature, with a clinical picture that is correspondingly lacking in detail and hazy in outline."

Although nutritional diseases are manifestations of the prolonged consumption of diets deficient with respect to amino acids, minerals, and vitamins, students of the problem agree (2, 4, 5, 6) that elimination of malnutrition is primarily a problem of increasing the variety of foods regularly eaten. Special emphasis should be placed upon the judicious consumption of familiar foods such as meats, (including glandular organs, poultry, sea food, and fish); eggs; milk in its many forms; milk products; fruits and vegetables; legumes; and the whole cereals and their various products. Thus, in its practical application (7), nutrition may be viewed as "an economic, agricultural, industrial and commercial problem, as well as a problem in physiology."

The nutritive values of canned foods have indeed been well established by means of numerous studies (8). By transforming foods, from the perishable condition in which they are harvested, to canned foods which may be stored for consumption in all seasons, the canning industry has rendered great assistance in carrying out the programme designed to eliminate malnutrition.

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1. 1939. J. Am. Med. Assoc. 112, 2110.  
2. 1938. J. Am. Med. Assoc. 111, 1073.  
3. 1940. J. Med. Assoc. Alabama 9, 365.  
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6. 1938. J. Am. Med. Assoc. 111, 1846.  
7. 1935. Quart. Bull. Health Organ, League of Nations 4, 326.  
8. 1939. Canned Food Reference Manual, American Can Company, New York

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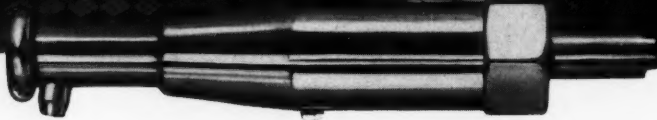
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# CANADIAN HOSPITAL

Toronto, April, 1941

Vol. 18

No. 4

## Air Raid Precautions and Hospitals

### 1. The Role of the Hospital

MAJOR R. C. MACDONALD

Commandant Area No. 2  
New Brunswick Civilian Volunteer Corps

**T**HE present period is, from the most authoritative sources, one in which "anything might happen" and in which nothing should be spared in preparation.

Might one, therefore, from this venture the following reasons why most hospitals which have not taken precautions do so at once:

(1) While not in emergency black-out or defended areas, they should be prepared to receive evacuees from maritime "defended zones".

(2) Because by reason of not being in black-out areas, their locality might be used as a "dump" for the raider who cannot locate his main target.

In the New Brunswick Civilian Volunteer Corps we have, we believe, organized all civilian effort into the best system possible, and one has not the slightest hesitation in recommending that other provinces, without complete groupings, write our provincial government for full information.

Committees embracing Billeting, Transportation, Protection (incendiary A.R.P. wardens, auxiliary fire fighters and police) and, last but not least, Medical Services, are combined under their authority.

Medical services embrace not only the hospitals but, in order that hospitals, doctors and nurses will only have the most urgent cases passed on to them, first-aid posts as well. (In our community with a population of approximately 28,000 including suburbs, seventeen have been established. Doctors and first aid workers will look after and return to their homes those but slightly injured and pass on to the hospitals through the aid-post transport only those who need hospitalization.)

Under the medical committees, St. John Ambulance courses are arranged, stretcher bearers instructed, and blood donors typed. The Red Cross co-operate in this work.

From the hospital and medical standpoint, it is good business to provide capable helpers to assist in any time of emergency, whether arising from war causes or not, and to help the medical authorities in event of an epidemic.

The householder further is encouraged to provide household first aid kits and in some areas the C.V.C. Transport plan to carry these.

I have had the privilege of looking over all reports Miss Wilson has received and, although some hospi-

tals report excellent preparations, it would appear that in others no unusual emergency preventions and preparations have been taken—the hospitals seemingly feeling that because black-outs are not being conducted in their immediate locality this is not necessary.

There is a Fifth Columnist we should like to corral and shoot. His name is known as "Complacency," his alibis are ignorance and indifference. There are many that say "why all the trouble, nothing is going to happen". Again many inhabitants in half a score of now conquered countries previously said the same, and it was by harrowing and discouraging unprepared civilians that victories were won.

Rodman Wanamaker was often "kidded" by his friends because he carried six millions of Life Insurance. They told him "You will never need it". His reply was, "It's better to carry it all my life and never need it than to need it for even a moment and not to have it".

Medical and hospital preparations are always necessary and never was there a time when it and other civilian preparations seemed to be more urgently required.



## II. Emergency Preparations in Public Hospitals Located in the Maritime Provinces

By **RUTH C. WILSON,**  
*Moncton Hospital.*

*Synopsized from an extensive survey of emergency preparations in the Maritime provinces made for the Canadian Hospital Council by Miss Ruth C. Wilson, the Secretary of the New Brunswick Hospital Association. For military reasons the hospitals are here designated by letter only.*

—Editor.

Headlines in the public press inform the general public of Canada that German long range subs may prowl Canadian seas. Another item noted in the public press tells of practice air-raid alarms and the intensive work performed by the C.V. C. (Civilian Volunteer Corps) to prepare for any possible emergency. This impresses any conscientious hospital administrator with the urgent necessity of taking suitable measures to conform to possible emergency needs within the area served by any particular institution.

Hospital magazines published in the United States contain many references to the situation confronting the North American continent to-day. Headlines such as the following hit the eye as one leafs the pages in the most casual fashion:

"If epidemics strike will hospitals be prepared?"

"We are already late in our preparations for aerial bombardment."

"Preparing for catastrophe."

"Oklahoma group told of need for emergency preparations."

Dr. Arnold F. Emch, A.M., Ph.D., under the title "The Role of Voluntary Hospitals in a National Emergency," has emphasized the folly of ignoring conditions which might easily prove an actual menace.

During the early winter the Canadian Hospital Council made a survey of civilian hospitals and discussed utilizing civilian resources in an emergency.

### A.R.P. and Maritime Hospitals

We are concerned in this present discussion with actual preparations made by hospitals in the Maritime provinces of Canada. A comprehensive survey was made, as a result of which it was evident that hospitals located in areas judged to be vulnerable to attack were quite thoroughly prepared to deal with almost any problem liable to arise under emergency conditions. Hospitals in these particular areas showed by their response to these inquiries that they were fully prepared to comply with any requirements made by the government, and it is reasonable to assume that this condition will be dealt with to the satisfaction of all authorities, probably before this article will appear in print.

For obvious reasons it is not possible to describe the very intensive preparations undertaken by the two largest public hospitals in the Maritime provinces. But the following examples reported by public hospitals at various points declared to be vulnerable, give a helpful picture of preparedness.

Hospital "A" reports:

(a) Air Raid Precaution Black-outs are carried out at frequent intervals. Our procedure is as follows: Our main dependence at the present time is "shut-off" so that we can be assured of having completely darkened rooms; tar paper is placed over the windows. In the operating room we have emergency battery-lit lights available. Further, electric torches are provided throughout the institution to be utilized for carrying on the ordinary duties on the floors, and as a further precaution, candles are supplied. All of our heavy window curtains have a black background presented to the outside and these can be quickly pulled together. The upper parts of the fan lights are painted black. Blue globes are used at the outside entrance. As soon as the air raid alarm is sounded, our organization immediately takes care of the lighting system which is controlled through the main switch.

### (b) Fire Protection

We have a fire and a demolition squad which work in conjunction and will be available in an emergency.

### (c) A safeguard against bombs

It is obvious that there is no safeguard against the ordinary heavy bomb and the only possible safeguard that can be followed to cover the fire bombs when they land on some part of the roof of the institution is the use of sand and various other devices. We have provided throughout the building large cans filled with five to seven pound paper bags of sand. We found that the large cans of sand were rather useless, as the weight was too great for the ordinary individual to move about. We therefore packaged the sand in relatively thin paper bags that can be easily handled. The procedure is to drop the bag onto the fire bomb; as the paper bag promptly bursts, good coverage is effected.

The building is equipped with a sprinkler system which will take care of minor fires. The greatest danger is on the roof, and here again we



have provided bulk sand, shovels and sand in paper bags.

(d) *Plans for receiving emergency cases*

Our whole organization is arranged for the care of emergency cases. We have four units for first aid. *Equipment:* each parcel has been sterilized and is well protected by many layers of paper and is readily available for the use of a unit in case of emergency. The units will consist of a medical man and a nurse.

We are training a group of nurses throughout the institution for the care of emergencies—such as haemorrhages that can be controlled by tourniquets or other means.

This equipment is available for any area wherein the A.R.P. feel such would be useful. Many hundreds of cases could be handled.

(e) *Setting up of reserves of provisions and other supplies*

We have a very considerable supply of emergency materials. We are developing, too, an entire scheme of action in case of real emergency. Our plan as outlined at present is as follows:

In case of a bombing attack an alarm will be given.

The medical staff are divided into units and each has an Action Station. In each Action Station the ordinary personnel have been taught stretcher bearing. If any immediate emergency arises, the nurse with that particular unit will take care of it until such time as medical help can be obtained (which will only be a matter of minutes). The up-patients in case of bombing raids are immediately evacuated from the building and must find their way to their homes, or to shelter. Those patients unable to look after themselves will be taken care of by the stretcher bearers and immediately placed in the basement, which is sheltered from shell fire and from penetration of bombs. This is purely an emergency measure.

Should the damage done to the institution be too great to let us "carry on", we have a reserve hospital, several miles from the city. We have also arranged with various organizations in the city to provide us with at least fourteen trucks for the handling of these patients in any type of emergency.

We also have a complete decontamination outfit, a unit which has

rubber gloves, rubber coats and hats, chloride of lime, tools, cross-cut saw, hammers, etc., always available; also six gas masks for those who must come in contact with fire areas.

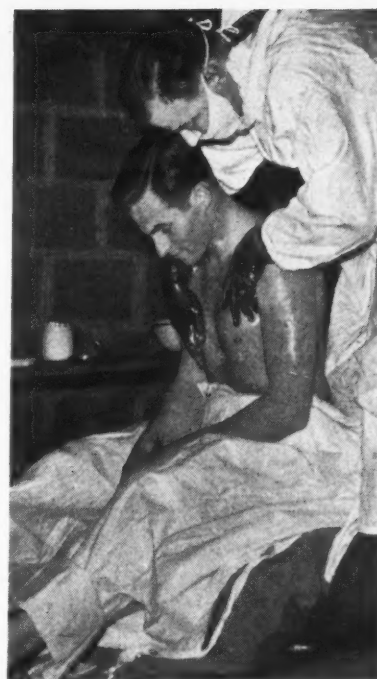
Hospital "B" reported quite similar precautions. The fire protection service is under the hospital engineer and facilities have been arranged whereby patients could be evacuated to a basement through underground passages leading from the main building. The hospital could accommodate quite a number of emergency cases especially if some of the wards be evacuated by moving the usual occupants into other parts of the hospital. This hospital keeps large supplies of meats and other foodstuffs on hand and has a reserve of blankets, dressings, etc., marked "to be used only in case of war emergency".

A large number of both patients and staff have been typed and would be available as blood donors. A list of doctors who would be prepared to take care of the injured in case of emergency has been supplied.

The windows of the operating theatre have been painted black in hospital "C". Here, too, sand, flash lights and emergency lighting, rubber coats, helmets and boots, and reserve supplies have been set up. Provision has been made for fifty emergency cases and a "call list" has been arranged with the medical staff.

Strips of beaverboard, four inches wide, running vertically along the sides of the windows in hospital "D" prevent cracks of light between the blinds and the wall. Blue bulbs on a separate circuit are arranged throughout. In case of disruption of electrical power, a large Burgess Lantern, flashlights and candles with matches are available. The latter have special glass shades fitted into tin stands to guard against fire. Special emergency orders assigning duties to each of the personnel have been posted.

In addition to the usual preparations for the reception of emergency cases, this hospital has listed the student nurses who could stay with relatives or friends in the city, thus liberating rooms for emergency use. A rehearsal of the black-out programme is held periodically and printed air-raid precautions, issued by the Halifax Air Raid Precaution



*Applying chloride of lime paste after exposure to mustard gas*

Committee, stand posted on all bulletin boards.

Hospital "E" instructs the personnel to wheel beds into the corridors where patients may be comparatively safe from flying glass and debris. Nurses have been given a refresher course covering general nursing but stressing operating room technique. The Red Cross has been asked to furnish material necessary to keep four operating rooms supplied for twenty-four hours of continuous use.

By means of a master switch, every light in Hospital "F" can be extinguished at once. Here a well, 125 feet deep, has been drilled and a pump attached; this will supply 500 gallons per hour.

Hospital "H" has converted its nurses' recreation room into an eight-bed ward. One year's supply of medical and surgical necessities is in reserve. All exit doors in the hospital open outwards.

The nurses in hospital "I" have been given extensive first aid instruction by the St. John Ambulance Association.

The construction of openings in lofts and attics and the provision of ladders, shovels, sand and fire extinguishers is reported by Hospital "J". The whole building has been carefully examined by fire inspectors and other officials for possible de-

iciencies and tests were made night and day to detect any danger point. A complete fire alarm system connecting all buildings with the superintendent's office was installed. Blackout precautions at doors were tested.

Outside buildings of wood were demolished. Paper records were transferred to basement files and x-ray films over six years old were destroyed. Fire escapes were repaired, fire directions posted and red signal lights installed. Fire drills are being carried out.

All available space has been surveyed with the result that it is estimated that three hundred emergency cases could be looked after by utilizing all floor space and by using mattresses. Unfortunately a number of the replies, particularly from smaller hospitals indicate that very little has been done to meet any possible emergency in these hospitals.

Here is a recommendation of value: Secure numbered Red Cross Arm bands from the proper source, register them in a book kept by the A.R.

P. and by institution authorities separately, issue them to employees by name for identification and then have these individuals keep these bands on their person in order that they may be enabled to move through closed traffic back to their duties at the hospital should they be required to report for service. Should a change in personnel be made from time to time, transference of these arm bands from one to another should be recorded.

#### Conclusion

It is our conviction that preparations of this nature serve a two-fold purpose:

(1) They meet the requirements for emergency preparations in war time;

(2) They have a very salutary effect on the general well-being of every institution undertaking the work.

The *minute inspection* necessary before any work is undertaken brings to light conditions which should be intolerable at any time but which

are accepted until necessity points the way to correction. Among these conditions may be included inaccessible attics and lofts, cluttered up with inflammable junk of all descriptions; closets and cupboards containing paper records which have long since become obsolete and merely present a fire hazard; defective or inadequate fire precautions; poorly constructed or defective fire escapes; wooden makeshifts and temporary partitions constructed of highly inflammable material; hospital personnel poorly trained or completely ignorant of fire precaution regulations.

It may be stated, therefore, that even though our emergency preparations might not be necessary and may never be called upon to serve the purpose for which they were designed, their adoption as an educational and disciplinary exercise is a measure of inestimable value. These precautions with modification have a logical place in a peace time world as well as in one of war.

### III. Basic Principles in A. R. P.

Major C. S. G. ROGERS, C.V.C.

In considering the preparations made by the various Maritime hospitals, it would be well to consider what form of enemy activity the authorities have asked us to be prepared to meet and then, as a "composite" recommendation, to pick from the reports submitted those features that are best adapted to meet these requests.

To begin with, we are fairly remote from enemy bases, and our coasts have three main defenders—the British Navy, our own Canadian Navy and the Air Force—and in addition the chain of defence stations which our friends from the United States and ourselves are creating along the Atlantic seaboard; this is in addition to our own military coastal defence.

These factors suggest that hostile activity, if it comes, will take the form of *air bombing raids*, and remoteness of enemy supply bases will

limit the load to be carried. This will tend to restrict the type of bombing to *incendiary activity* and not to high explosives, for incendiary bombs are relatively light in weight and many can be carried, while high explosives are heavy and their effect is proportional to their weight, which restricts their use. *Fire*, therefore, appears our main foe, and towards this phase of attack our activities should be directed. From this point of view then let us take the best features from the detailed reports submitted as a desired composite.

#### Precautions

(1) Destroy visibility at night by black-out precautions. Extinguish unnecessary lighting. Shield windows.

(2) Protect against fire. Incendiary bombs are light in weight usually not over two or three pounds each. They will penetrate a roof but are likely to stop at the attic floor; do not throw water over them; it

only scatters their effect. Therefore, have sand available in boxes or pails, place sand on them and then, with shovels, lift them and place them in the sand receptacle, where they can be smothered and removed. Do not count only on throwing sand on them, for they will probably burn through the floor below. They should be handled quickly before bursting into full flame; with sand they are relatively easy to control.

To aid fire control, see that attics are clear. Now is your time to rid them of the accumulations that we have always felt should be destroyed, but have deferred action.

Black-out and fire precautions are, however, but idle phases unless all fully understand their duties. Organize to instruct your staff and arrange practices. Words are feeble without action. Above all, create in your organization the belief in the necessity of the duties assigned to them. Half-hearted support is fatal,

Major Rogers is a Director of the Moncton Hospital Board.





*A gun emplacement protecting Canada's Eastern Coast.*

Courtesy Public Information.

for it results in a preparation that a crisis may find lacking.

#### **Positive Actions**

So much for precautions, now for the positive functions of a hospital.

(4) Decide exactly what accommodation you have surplus to normal requirements. Be prepared to increase it. Halls and bare floor space can be used. Mattresses and pillows, blankets and bed-linen, etc., are required. Inquire where these can be obtained. In some districts pooled supplies are available.

(5) Arrange to receive your emergency cases. Your regular staff may be inadequate for this. Arrange, too, for additional resources even if emergency aids have to be called in. This

latter should be organized well in advance for some training is necessary. Have an understanding with the additional doctors required. Do not leave these arrangements to the last.

(6) Arrange additional food, medical and surgical supplies. Base this on the additional patients that your survey has shown you can accommodate. Remember that fire is our main foe and be prepared to treat burns and injuries from this source. (See Addendum.)

(7) Make inquiries to see that other disaster services are prepared to render first aid and transport injured to the hospital. Additional ambulances will be the duty of other services in larger centres, but will be

the hospital duty in the smaller centres."

(8) Finally study carefully your own situation. There may be features familiar to your own needs and your own hospital that require a special treatment that only the individual hospital can determine.

#### **Addendum**

In commenting on these three articles, a high official at Ottawa added the valuable suggestion that dressings should not be left too long after sterilization in reserve stores. Despite every care in wrapping and storage a certain degree of contamination is apt to take place. Reserve stores should be used and replaced as used.

—Editor.

## **La defense anti-raïd et les hôpitaux**

### **I. Le rôle de l'hôpital**

**L**ES autorités les plus compétentes s'accordent à dire que "tout est possible", par les temps que nous traversons, et qu'aucun mode de protection ne saurait être négligé. L'auteur se permet de faire quelques suggestions, espérant qu'elles seront prises en bonne part par les hôpitaux qui n'ont pas encore pris toutes les précautions d'urgence, en cas de raids aériens.

a) Les hôpitaux non situés dans les zones défendues ou assujetties aux obscurations ou autres obligations militaires, devraient néanmoins prendre les mesures d'urgence nécessaires, leur permettant de recevoir les évacués des zones attaquées.

b) Ces mêmes hôpitaux, par raison de leur situation géographique, ne sont pas nécessairement à l'abri des raids aériens et peuvent, dans bien des cas, recevoir les obus destinés à d'autres endroits qui n'ont pu, pour certaines raisons, être localisés par les bombardiers.

Le corps volontaire civil du Nouveau-Brunswick, croyons-nous, a réussi à organiser un service civil d'urgence très adéquat, pouvant servir de base à des organisations similaires dans d'autres localités. Le gouvernement de la province possède les détails complets touchant notre organisation, et se fera un plaisir de les communiquer sur demande.

**Par le major R.-C. MACDONALD**  
**Commandant du district militaire numéro 2**  
**Corps volontaire civil du Nouveau-Brunswick**

En résumé, notre corps volontaire civil pourvoit à la distribution des billets de logement, au transport, à la protection de la population civile, dans les cas de conflagration, et enfin, aux soins médicaux.

En ce qui a trait aux services médicaux, il est prévu que seuls les cas d'extrême urgence soient dirigés vers les hôpitaux; les pansements et traitements ordinaires devant être confiés aux différents postes d'urgence, au nombre de 17, pour une population de 28.000 habitants environ; chacun de ces postes est pourvu de pièces à pansements, médicaments, etc.

A l'Association ambulancière Saint-Jean (St. John Ambulance), incombe la tâche de transporter à leur domicile, après pansements, les blessés ne nécessitant pas l'hospitalisation; ceux qui sont blessés plus grièvement sont dirigés vers les hôpitaux. L'Association organise, conjointement avec la Société de la Croix Rouge, des cours spéciaux touchant les soins médicaux, le transport des malades et la classification des donneurs de sang.

Au point de vue hôpital, nous sommes d'avis qu'il y aurait lieu de recruter un certain nombre d'employés, à qui un entraînement particulier serait donné. Des équipes de ce genre rendraient des services appréciables, — qu'il s'agisse d'urgence provenant de l'état de guerre ou d'épidémie.

Il nous a été donné d'examiner certains rapports d'hôpitaux sur les préparatifs qui ont été faits à date, et nous constatons avec plaisir qu'un certain nombre d'organisations hospitalières ont pris les dispositions qui s'imposent, afin d'accorder à leurs localités respectives le maxi-

mum de protection. Dans d'autres cas, toutefois, il semble qu'aucune précaution n'ait été prise, en cas d'urgence, dû au fait que l'obscurité n'est pas de rigueur dans le voisinage immédiat, — ces précautions étant jugées inutiles.

L'insouciance de certains est en tout point comparable à celle des Européens dont les pays ont été conquis, et qui, jusqu'à leur défaite, ne voyaient aucun danger. Nous insistons sur la nécessité d'être prêts à toute éventualité, en tout temps.

## II. Préparatifs d'urgence dans les hôpitaux généraux des Provinces Maritimes du Canada

*Par Mademoiselle RUTH-C. WILSON,  
Secrétaire de l'Association des hôpitaux  
de la province du Nouveau-Brunswick*

*Résumé d'une enquête approfondie sur les préparatifs d'urgence dans les Provinces Maritimes. Pour l'information de nos lecteurs, les hôpitaux des Provinces Maritimes, vu l'état de guerre, sont identifiés par le moyen d'une lettre.*

*Editeur.*

Des articles de journaux rapportent, chaque jour, les faits et gestes de l'ennemi, les moyens ingénieux à sa portée, lui permettant d'entreprendre des raids aériens de plus en plus destructeurs, la possibilité d'augmen-

ter considérablement les distances à parcourir, etc., les sous-marins à longue portée, qui, déjà, patrouillent les côtes de l'Amérique du Nord. Ces faits ne sont-ils pas suffisants pour nous faire réfléchir? Les journaux et périodiques de l'Amérique du Nord en général publient sans cesse des nouvelles à sensation, qui, croyons-nous, devraient éveiller notre instinct de conservation. Citons quelques entêtes d'articles pris au hasard:

"Au cas d'épidémie, nos hôpitaux sont-ils préparés?"

"Nous sommes déjà grandement en retard dans nos préparatifs contre les raids aériens."

"Préparatifs en vue d'une catastrophe."

"Un groupe de citoyens de l'Etat de Oklahoma demandent si nous possédons les moyens de parer à toute éventualité."

et combien d'autres avertissements encore. . . .

### Résumé concret des rapports reçus d'un certain nombre d'hôpitaux des Provinces Maritimes

Hôpital "A."—Nos moyens de protection sont: obscurité—exercices de sauvetage fréquents.

#### Précautions

Entrée principale fermée au public, permettant un contrôle absolu, lors du signal d'obscurité.

Papier noir masquant toutes les fenêtres.

Dans les salles d'opération, lumières d'urgence indépendantes du système d'éclairage ordinaire.

Torches électriques en permanence dans tous les postes de service, et aussi, chandelles.

Toutes les fenêtres pourvues de stores épais, noirs à l'extérieur.



*The Morning After—in a Hospital Ward.*

Personnel spécial chargé du système d'éclairage.

Hôpital "B."—Organisation d'une équipe volontaire de pompiers et de démolisseurs.

Hôpital "C."—Personnel de pompiers volontaires en disponibilité dans tous les endroits dangereux, sacs de sable, pelles et autres instruments d'urgence. A noter: nous nous servons exclusivement de sacs de papier,—notre expérience ayant démontré qu'ils sont plus pratiques que les sacs de toile ou autres. Le sac au complet est jeté sur la bombe incendiaire, et comme il brûle rapidement, il couvre entièrement le feu.

Hôpital "D."—Nous avons organisé quatre équipes composées d'un médecin et d'une infirmière. Le matériel à pansements est préparé, stérilisé et mis en paquets recouverts de plusieurs épaisseurs de papier,—le tout en quantité suffisante pour quelques centaines de cas, à la disposition des membres de l'équipe seulement.

Hôpitaux "E," "F," "G," "H," "I," "J."—Organisation d'équipes d'urgence pourvues de matériel à pansements, gants de caoutchouc, paletots et bottes caoutchoutés, pelles et outillage nécessaire à la démolition. Chaque équipe est sous la direction d'un médecin, assisté d'une infirmière,—cette dernière devant prendre charge de l'équipe avant l'arrivée du médecin.

Entraînement d'ambulanciers pour le transfert des malades allités des diverses sections de l'hôpital, au sous-sol, en cas d'urgence. Les malades non allités sont renvoyés dans leurs foyers, ou doivent se diriger vers les abris anti-bombes disponibles.

Advenant la possibilité de la destruction de l'immeuble pendant un raid, le transport des malades à un hôpital (de réserve), situé à plusieurs milles du centre, sera effectué par quatorze camions-automobiles mis à la disposition de l'hôpital, au besoin (ceci s'applique à l'hôpital, "E").

Une quantité considérable de viandes et autres comestibles fait partie d'une réserve d'urgence.

Fenêtres masquées — lumières sombres—torches électriques en nombre suffisant dans toutes les sections de l'immeuble—exercices de sauvetage fréquents—usage des chambres des élèves-infirmières pour l'hospi-

talisation des malades, si nécessaire,—puits muni d'une pompe pouvant assurer un rendement indépendant de cinq cents gallons d'eau par heure.

Inspection complète de l'immeuble par les inspecteurs des incendies, en vue de découvrir ses points faibles—organisation d'un système d'alarme contre l'incendie, ralliant toutes les parties de l'hôpital au bureau du surintendant—démolition de certaines maisons de bois qui entouraient l'hôpital—mise au point des échelles et autres appareils de sauve-

tage—destruction des négatifs radiographiques de plus de six ans—usage des couloirs et de toutes les sections non réservées aux malades, augmentant ainsi la capacité hospitalière d'environ trois cents lits, en cas d'urgence.

#### Conclusion

Nous avons la ferme conviction que des préparatifs de cette nature ont pour double but :

Premièrement, d'assurer une protection adéquate en temps de guerre;

Deuxièmement, de créer une impression de sécurité et de confiance.

### A. R. P. on the West Coast

Inspector S. F. M. Moodie, Provincial Civilian Protection Officer of the Civilian Protection and Air Raid Precautions Branch at Victoria wrote under date of March 6th:

"Our two largest vulnerable areas are known as the Greater Vancouver and Greater Victoria areas. Dr. Stewart Murray, M.H.O., Vancouver, and Dr. Richard Felton, M.H.O., Victoria, are respectfully in charge

of such arrangements for the two areas.

"Danger has not appeared as yet to be so near to us as to those in the Maritime Provinces. The officials mentioned above have surveyed emergency hospital accommodation, drawn plans for activities when such are indicated, and planned for the use of certain government institutions as it becomes necessary to take these over as an emergency measure."

### Sixty-Five Thousand People Organized for A.R.P. Work

The extent to which A.R.P. organization has progressed in Canada was revealed in the House of Commons on March the 20th when the Hon. Ian Mackenzie stated that 65,000 persons are organized for A.R.P. activities. This number included 1,438 doctors and 3,119 nurses. Many thousands of those registered have completed their training in first-aid, and the health department has a record of nearly 39,000 first-aid certificates issued by the St. John Ambulance Association in 1940. More than 23,000 persons have received training to qualify them to serve as air raid wardens and about 4,000 volunteer firemen were taking training. More than 27,000 persons were trained in mobile squads to assist police in preventing disorder at the time of a raid. Provinces chiefly affected in the organization are Nova Scotia, New Brunswick, Quebec, Ontario and British Columbia. Extensive equipment has been supplied to these local organizations.

Last year the federal government appropriated \$100,000 and an expenditure of \$250,000 is planned for the coming fiscal year.

### Saint John General Hospital Increases Capacity

By removing nurses from the cubicles section of the infectious diseases annex and housing them away from the hospital, the Saint John General Hospital has increased its accommodation by 28 beds. Alterations and equipment for the property secured as a nurses' residence cost \$3,500.

### Government Cancer Clinic Opened In Calgary

The Alberta government opened a free cancer clinic for both diagnosis and treatment at the Holy Cross Hospital, Calgary, on March 28th. This is the second provincial cancer clinic to be established; the first was opened in Edmonton, early in the year. The government has voted \$45,000 for the operation of this clinic.



# Control of Radio Interference

THE long expected regulations governing radio interference were finally passed at the present session of parliament. These were announced in the *Canadian Gazette* of February 8th.

"The necessity of protecting radio communications, including those used by the fighting services, as well as broadcast reception, has obliged the Department of Transport to bring in regulations prohibiting, after January 1st, 1942, the use of spark-gap type diathermy apparatus and mechanical rectifiers for X-ray installations, unless such equipment is adequately shielded, thereby confining the radiation within reasonable limits, or their interference otherwise suppressed.

"The severity of the radio interference created by spark-gap discharges is, of course, well known to the operators of this equipment; it is quite capable of seriously interfering with normal reception over wide areas on broadcast frequencies and the detrimental effect to short-wave commercial and war communications is equally pronounced, even at greater distances."

Since 1925 engineers of the Department have conducted research work on the problem in an endeavour to develop an economical means of suppressing this interference. "From the mass of material accumulated it has become clear that filters alone will seldom provide the answer; complete shielding of the operating room or rooms, together with a suitable surge trap in the supply lines has been found necessary." Exhaustive researches have been carried out by the British Government and complete shielding is now being required in Great Britain.

"For the present, the regulations in Canada will not apply to short-wave therapy installations, unless they seriously interfere with some vital radio communication. It is not unlikely, however, that they will ultimately be extended to include this equipment as well. It has been suggested that specially designed apparatus of this type might be permitted to operate in a restricted frequency band, thereby obviating the necessity of shielding, but the indications are

that such special equipment will not be available for several years—if at all."

It is anticipated that proper steps to suppress radio interference will be taken by hospitals and by practitioners without delay. In order that no undue hardship will be caused to the operators concerned the **Department of Transport has set the date for compulsory interference suppression as January 1st, 1942.**

## Specifications for Shielding

"Radiation from high-frequency generators, if not properly controlled, causes interference by:

- (1) Direct radiation;
- (2) Conduction along any power or communication wires;
- (3) Radiation from grounded metallic objects including the shielding itself, the grounded wires from the shielding, piping or building structure;
- (4) A combination of two or more of the above.

"The shielding must be complete, that is, there must be no openings having a circumference of more than two inches without effective bonds, except in cases where the shielding metal is adequately over-lapped."

The following materials are effective for shielding if properly applied under suitable conditions:

### (1) Copper Foil:

Extremely thin copper foil is electrically suitable, but the foil should be of a sufficient thickness to provide mechanical strength in handling and reasonable life against corrosion. A weight of copper having one ounce per square foot may be used.

### (2) Aluminum Foil:

Aluminum foil may be used in a similar way to copper foil. Aluminum foil can be purchased commercially about 1/2000 of an inch thick. A metal-coated paper may be obtained, either plain or with designs embossed, and used as a wallpaper when necessary precautions are taken for bonding and overlapping the joinings. Before deciding on a metal-

coated wall paper a sample should be submitted to the radio inspector, to ensure that it is made of continuous foil of sufficiently low resistance, for the reason that types of metallic wallpaper using metal powder in the manufacture do not provide a surface of sufficiently low resistance. Moisture-proof glue should be used in the manufacture of the paper.

### (3) Metal Lath:

Expanded metal lath provides satisfactory shielding when it is properly installed, bonded and passes the required inspection.

### (4) Woven Wire:

Many types of woven wire metal are suitable for shielding provided that the mesh opening does not exceed three quarters of an inch and that the bonding around each opening remains perfect. Wire mesh, which is not bonded, after weaving, by galvanizing or other means, is not suitable, as it is found that the surface of even bronze and copper wire will corrode sufficiently to produce a high resistance contact and, thus, considerably reduce the effectiveness of the bonding. Copper or iron wire, galvanized after weaving, is recommended. Iron wire is nearly as effective as copper in shielding against high frequency radiation.

### (5) Sheet Metal:

Sheet metal is preferred to foil in some cases, on account of convenience in installation and mechanical strength, and it provides a satisfactory shield.

## Suppression of Radiated Interference

The detailed instructions issued by the Department recommended that shielding material should be overlapped by about two inches. Moreover, soldering or spot welding is recommended. All pipes or metal passing through the shielding should be thoroughly bonded to the shielding. Such piping should be grounded. With gas pipes an electric bond should cross the meter.

There should be a continuous

The CANADIAN HOSPITAL





## Whoops Laddies!

Mon, it's a gran' game and it's a bonny nicht, too, when Alberta takes the cup in the Dominion curling finals with the President of the Dominion Curling Association, himself from Alberta, looking on.

With true Scotch modesty, Dr. A. F. Anderson of Edmonton, retiring President of the Dominion Curling Association and now its Honorary President, claims that he only ranks as a spectator and that he plays his best game "watching through a window at the end of the rink". At any rate he must be a fine spectator, for this year the brooms from Alberta swept the way clear to the coveted Dominion championship decided a few weeks ago at the Granite Club in Toronto. Our staff artist caught the spirit of that glorious occasion.

Incidentally, during "Andy's" tenure as president this past year, Canadian curlers donated \$15,000 to the Canadian Red Cross Society, and donations are still being received.

bond to all door, window and ventilator openings. Screens on these openings should make a continuous bond throughout their entire periphery. Naturally all doors, windows and other openings should be continuously shielded. A gap below the door must be guarded.

In a steel building bonds should be made to the structural steel with leads as short as possible from all sides of the room. All grounds should have as low impedance as possible.

There is a considerable field of radiation within a few inches of all shielding and, therefore, unshielded wires must be kept at least one foot from the outside of the shield. Conduits should not come within two inches of the shielding.

### Suppression of Conducted Interference

All electric light, power and signal wires entering the shielded room or close to the shield on the outside are liable to pick up the interference. It is necessary, therefore, to overcome this by means of surge traps or other methods.

- (a) Tuned Surge traps—consist of inductors or capacitors, or a combination of both.
- (b) Shielded transformers are most satisfactory to prevent conducted interference over a wide frequency band.
- (c) Shielding is an alternative method. Lighting may be provided by a dome light in the ceiling covered with bronze gauze well bonded to the shielding of the ceiling. The lighting may be supplied through the same shielded transformer that supplies the radio frequency generator. The most economical way of shielding communication circuits is to have the telephone and signal system placed in an adjoining room.

No part of the apparatus should be within one foot of the shield. The generator should be on an insulating or metal stand and, if metal, it should be grounded. The leads should not come within one foot of the wall or floor.

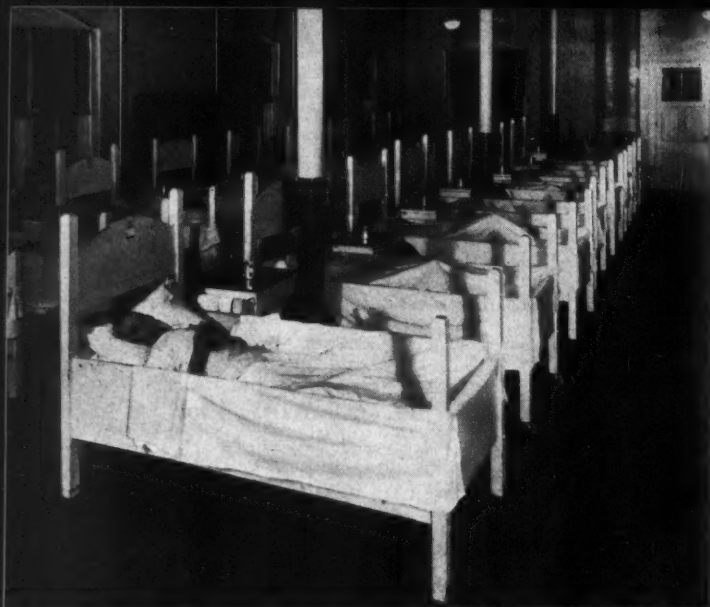
### Prevention of Shock or Burns

As the patient or operator in the field of the high frequency generator might receive an unpleasant shock or burn should he come in close proximity to any grounded metal, it is recommended that insulating material be placed on the walls and floors in the vicinity of the treatment stand or operating table.

As all occupants of the room under some conditions may be subject to an electrostatic charge "it might be advisable to provide insulation at places where such occupants may come in contact with the shield; such places to include the handles of the doors, etc."

Every effort has been made by the Department to cause as little inconvenience or expense as possible to operators of electrotherapy equipment and repeated warnings have been issued. Most new equipment is now radiation-free. The Minister, however, after January 1st, 1942 may order the suppression of interference from any apparatus and a penalty

(Continued on page 54)



## SAWDUST BEDS

### Ideal for Certain Conditions

**T**HE prevention and treatment of bedsores is one of the most difficult and vexing problems which faces the nursing staff of a hospital. To a hospital which houses the chronically ill, the aged and the infirm, the problem is an especially difficult one. And yet the Hamilton County Home and Chronic Disease Hospital, with a large percentage of its patients particularly prone to bedsores, has solved the problem with an amazingly simple treatment—sawdust beds. Haddassah M. Hoffmann, R.N., matron of the hospital, tells the story of seven years successful use of sawdust beds for the treatment of bedsores, incontinence and other conditions, in the March issue of *The Modern Hospital*.

For patients who are incontinent, or who have a rectal or a vesicovaginal fistula, sawdust beds present many advantages. For instance, the incontinent patient in an ordinary bed with a rubber draw sheet and a muslin draw sheet, is lying in a soiled bed most of the time. This is inevitable, even if the bed is changed 15 to 20 times within the 24 hours. Heat and moisture are the best mediums for growth of bacteria and, if there is any break in the tissues a bedsore will soon develop. A dressing over the lesion simply helps the bacteria to grow. The same patient in a sawdust bed presents a much happier picture. The sawdust rapidly absorbs the moisture and the patient is lying in a dry bed at all times. There is enough ventilation through the sawdust to allow the body heat to escape and cooler air reaches the wound every time the

patient turns. It has been found, too, that there is just enough irritation in soft sawdust to stimulate granulation in the wound. With no other treatment other than washing with soap and warm water or warm normal saline solution bedsores have disappeared in record time in sawdust beds.

The construction and care of the sawdust bed is quite a simple task. The framework of the bed consists of the head, foot and legs of the standard bed, fitted with rubber casters. The body or "crib" of the bed is made of white pine or cypress wood. Inside measurements are: length 7 feet; width, 32 inches and

depth 15 inches. Glueing of the joints of the bed during construction prevents seepage of sawdust. Sawdust made from white pine or any soft wood and sifted to remove splinters is placed in the bed to a depth of about 8 inches. A quilted pad or a folded draw sheet, 25 by 30 inches is placed at the head end of the bed and the pillows are placed on it. A sheet, a spread and, if necessary, a blanket are used as covering. These can be either pinned or tied to the foot of the bed to keep them from slipping to the floor. The covers are fan-folded and the bed is complete.

*(Continued on next page)*



*Photographs Courtesy The Modern Hospital.*

**The CANADIAN HOSPITAL**

The patient is placed directly upon the sawdust and no lower sheet is used. A backrest or a wooden tray stand for writing are used just as in the ordinary beds.

Treatment of an open lesion consists of daily (more often if necessary) washing with soap and warm water or with warm normal saline solution. No medications or dressings are used. Sawdust soiled from wound discharges or excreta is removed with a scoop or dustpan, placed in an airtight galvanized container and burned in the incinerator.

The sawdust is loosened daily with a wooden paddle and is changed completely every other week, or more often if necessary. When a bed is vacated, it is cleared of old sawdust, washed with soap and water and aired.

Not only have these sawdust beds proved to be the best treatment for bedsores, but they have meant a great saving in linen, laundry and dressings. They are an excellent labour saving device for the nurses and they keep the wards clean and eliminate odours. Patients like them so well that they have frequently asked to remain in the sawdust beds.

#### **Toronto Hospital Council Approves Increase in Rates**

At the March meeting of the Toronto Hospital Council, it was revealed that per diem costs have risen tremendously since the outbreak of war. One hospital reported that its public ward costs had already advanced twenty-one cents per diem and its private wards sixty cents. Another reported a private ward increase of fifty-four cents per diem. Other administrators reported increases approximating these figures. It was agreed that pay public ward charges should be increased as of April 1st from \$2.35 per diem to \$2.50 per diem. As already required by the provincial government, extras will be charged these patients at fifty per cent of the regular charges.

The Toronto Hospital Council also approved the principle of the raising of semi-private and private rates by the individual hospitals to approximate the rising cost of providing these services.

Arthur J. Swanson was elected chairman to succeed Chester J. Decker, retiring chairman. J. H. W. Bower was elected vice-chairman and M. T. Morgan secretary-treasurer.



## **Health Hazards in Industry**

THE enormously increased activity in the munitions industry of this country gives a new urgency to the problem of occupational health hazards. As a result of what was at times the very costly experience of the last war, there is today considerable knowledge concerning the occupational diseases of this industry and we are now in a far better position to cope with them than were health officials at the beginning of the last war. Kingsley Kay, M.A., Ph.D., Industrial Hygiene Engineer of the Department of Pensions and National Health, has written a brief review of the subject entitled "Occupational Hazards in the Munitions Industry", which was published in the *National Health Review*, a government publication. The article was written to "foster a general awareness of the potential health problems involved", pending a more detailed discussion of the subject being prepared by the government for distribution to the medical and engineering professions.

Apparently the greatest dangers to workers in this industry are not due so much to the explosive property of the substances being manufactured, "but rather to the toxicity of the substances to which they are exposed". One of the great hazards in the manufacture of explosives is exposure to excessive concentrations of nitrogen fumes; the toxicology of the nitrogen oxides is well known. Another hazard is exposure to solvent vapours, particularly to diethyl

ether, which may be present in connection with the manufacture of nitrocellulose.

Trinitrotoluene, commonly used as a high explosive, is a highly toxic substance and was responsible for a great deal of occupational disease in the munitions industry during the last war. Amatol, a mixture of ammonium nitrate and trinitrotoluene, possesses the same toxicologic properties. Most of the cases of trinitrotoluene poisoning occurred in connection with the filling of shells with this substance, rather than in its manufacture; by filling shells with the materials in molten rather than dry form, by provision of adequate ventilation, care in personal hygiene and good housekeeping, the danger of exposure is "considerably diminished". After a brief classification of symptoms and best diagnostic methods, Kay reports that in the last war British authorities "relied eventually upon a strict preliminary medical examination of prospective workers" to eliminate workers with anaemia, liver impairment and dyspeptic derangements.

Poisoning from nitroglycerin, though less important than trinitrotoluene, caused some morbidity and mortality in the last war. Severe headache, insomnia, diarrhoea and vomiting, lowered blood pressure, slow heart action, cyanosis and even paralysis indicate poisoning. Acclimatization may be built up but is quickly lost.



# The Training of V.A.D.'s in Canada

## Should Hospitals Give Practical Training?

MUCH discussion has taken place as to whether or not V.A.D.'s should be trained in Canada. Is there any particular need for this type of worker in this country or for overseas services? If training should be given, should it be of an elementary or of an advanced nature and to what extent should civilian hospitals participate?

These and other questions have been of considerable concern both to the hospitals approached by certificate holders for ward training and to those national bodies interested in providing the courses. On January 4th, 1940, a conference was held in Toronto attended by representatives of the Canadian Red Cross Society, the St. John Ambulance Association, the Canadian Nurses Association and the Canadian Hospital Council. At that time it was agreed:

THAT in view of the fact that neither the Department of National Defence in Canada nor the Joint Committee of the St. John's Ambulance and Red Cross in England can at the present time use V.A.D.'s either at home or abroad, this Joint Committee does not recommend any hospital or advanced training such as is required to qualify applicants for V.A.D. work.

Realizing, however, that the war situation might require a change of viewpoint it was agreed that a syllabus for advanced training for V.A.D. workers should be drawn up and be available for such an emergency. This was done by a sub-committee under the chairmanship of Miss Elizabeth Smellie of Ottawa, now Matron-in-Chief of the Department of National Defence but at that time representing the Canadian Nurses Association. This committee recommended *inter alia*:

(a) Courses of advanced training should be given in military hospitals or military wards in recognized general hospitals and under the direct supervision of fully qualified nurse instructors and supervisors;

(b) Two months of not less than

four hours daily, including Sundays, on hospital wards should be considered satisfactory for practical experience;

(c) An agreement should be signed for a definite term of service;

(d) The nursing syllabus outlined in the report should be carefully elaborated.

The report included, also, reference to personal qualifications, age limits, height, health requirements, provisional regulations and routine, and a hospital release form.

At a meeting on September 11th, 1940, held at the national headquarters of the Canadian Red Cross Society, this report was adopted and it was recommended that this matter be referred to the Minister of National Defence.

Since that date, as a result of discussions and correspondence between the Canadian Red Cross Society and the St. John Ambulance Association, it has been agreed by the two organizations that those women who take the Red Cross course in home nursing shall be eligible to sit for the examinations of the St. John Ambulance Association upon payment of the \$2.00 fee. As a result of this arrangement, although two preliminary courses are available, the examination of one body may be taken at the completion of either course. The Department of Defence at Ottawa has since stated that, should it be decided to use V.A.D.'s, certificates in both home nursing and First Aid would be necessary as minimum requirements.

As far as is known, no further action has been taken with respect to the adoption of a curriculum for advanced training as adopted by the joint committee last September. This has been due, it would seem, to the fact that there has been no obvious need for setting up an advanced course. No official statement has been made, to our knowledge, concerning type of instruction, recommended length of course or other details. We have been informed that

if, in the future, it becomes expedient to request the provision of hospital experience under supervision in civilian hospitals, such co-operation as that which might be available in civilian hospitals might be sought. No decision, however, has yet been made. We are further informed that military hospitals are not at the moment prepared to undertake this responsibility, but if and when such service is required, the matter will be further considered. One would infer that the Government does not feel that the situation demands further elaboration or action at the moment. It would appear that no intimation has come from the United Kingdom that there is need for any Canadian trained V.A.D.'s for service overseas.

Some nursing instruction is now being given in certain Canadian hospitals. At Victoria Hospital in London, Ontario, a dozen young women who have taken the St. John Ambulance Association course have been permitted to observe hospital procedures. They serve in groups of four for a period of four weeks carrying trays, assisting in feeding the patients and observing the nurses' routine. They have no responsibility for the actual nursing care of the patient. At the Royal Jubilee Hospital in Victoria, B.C., a group of some forty certificate holders are permitted to work on the wards in groups of three or four for a two weeks' period or longer. These young women serve as ward helpers, not as V.A.D.'s, and are being trained for emergency work on Vancouver Island and not for overseas service. At Halifax the board of commissioners of the Victoria General Hospital were requested to provide facilities for observation and instruction in nursing for a group who had received their home nursing certificates but it was decided unwise to establish such a course at the present time. A small group is now being given some training in practical nursing at the Women's College Hospital in Toronto.



# With the Hospitals in Britain

By "LONDONER"

Dear Mr. Editor:

It gives me much pleasure to respond to your very kind invitation to let you have a monthly story of happenings in Great Britain. Instead of writing a "London Letter" I have adopted your wider title, as that conveys the most salient fact in the hospital service of the country at the present time. The redistribution of population has taken place on a large scale. An official communication from the Bank of England may come to a place almost unknown to me in the South of England. A colleague in hospital matters, who normally works from an office in Trafalgar Square, is now with his staff in a little place in the west of Scotland. And so one might cite examples almost indefinitely. This removal of the population has taken place from all the principal urban centres as well as London and extends to all classes of the community. In particular, large numbers of working class people, especially women and children, have moved from bombed areas to sparsely populated districts. This has involved a considerable extension of the public health services, particularly maternity and child welfare. Similarly hospitals find themselves called upon to provide for a largely increased population. There is also another factor which adds to the demands upon their accommodation.

## The Effect of Air Raids

The extensive bombing of selected towns has been followed by air raids by one or two aircraft scattered all over the country. The hospital in a small town in a safe area, which had previously been exempt from raids, may suddenly find itself called upon to accommodate twenty casualties. For a hospital with only a hundred beds this, as will be appreciated, is not an easy matter. The result is that hospitals, which have been able to continue their work almost as normally, have now found it necessary to keep ten or more beds available for emergencies. The casualties are more widely distributed with the

result that the beds reserved in the danger areas are less in demand. Previously, we were thankful to find, the original estimate of the Ministry of Health had been greatly in excess of the requirements even during the worst periods of air attacks. The Government still warn us, however, that there may be need for them. The direct attacks upon hospitals in urban areas has made a considerable reduction in the number of beds actually available though efforts have been made to maintain something near to the original figures, while the ordinary sick from the remaining population are transferred to outlying hospitals.

## Protection from Fire

The immediate work in hand at the time of writing is the effective organization of a Fire Guard. We have all had the A.R.P. (Air Raid Precaution) Services, which have included provision for dealing with fire, but the development of aerial attack by the distribution of literally hundreds of small incendiary bombs has necessitated special measures of defence. The Minister of Home Security has said that hospitals are "business premises" for the purpose of his orders on the subject. Under

other conditions we might have taken exception to this definition of a hospital, but most of us were already alive to the fact that hospitals would have to organize their staffs on lines similar to those in operation in factories and places of business. We had already adopted the "spotters" system whereby, upon the sounding of the "Alert" by sirens, two men are stationed on the roof to give a warning within the building of the imminence of enemy aircraft. They will now be supplemented by men whose business will be to look down instead of up to detect any incendiaries falling on roofs. The latter will give warning to a number of fire fighters always on duty according to a two-hourly time table. Experience has shown that effective and prompt action can reduce the amount of damage from this form of attack to almost negligible dimensions. The element of risk to the fire fighters lies in the fact that some of these bombs contain a certain amount of explosive, so that staffs are receiving special instruction in the correct methods to handle them.

Permit me to sign myself as a Freeman of the City of London as well as a life long resident.

—Londoner.

## A Message to British Hospitals

MALCOLM MACDONALD, formerly Britain's Minister of Health and recently appointed British High Commissioner to Canada, has warmly praised British hospitals.

"There can be no one who has not constantly in mind the vital part which the hospitals, and all the individual workers associated with them are playing in the present ordeal. There has certainly never been a war in which so much depended upon the home front and the determination and courage with which it is held. The succouring of the casualties incurred on that front, whether sick or wounded, is one of the most important parts to be played in the struggle. While the day to day achievements of the hospitals are speaking for themselves so clearly, no added praises are needed; but to me the highest praise of the hospitals is to say that in rising to every occasion so magnificently and under every sort of difficulty, they have done just what everyone expected them to do—and could not have done more than that."

"I wish all concerned good luck, and I congratulate them."

—From The Hospital (London).

# Obiter Dicta

## *Hospitalization of Soldiers' Dependants*

**P**ROTESTS are continuing to be received over the difficulty of collecting accounts for the hospitalization of soldiers' dependants. While some hospitals have not had much adverse experience, others have accounts amounting to thousands of dollars incurred by soldiers' dependants for which collection seems impossible. Municipalities do not feel that they can recognize such patients as indigents in view of the fact that they are receiving monthly allowances which, in the majority of cases, are deemed ample for their needs.

Many people are involved. Up to the end of January, 1941, the Dependents' Allowances Board had a total of 109,000 accounts, of which approximately 97,000 accounts were for wives and children. The total number of children covered in these accounts for whom allowances are being paid was approximately 114,000. The total number of children in dependent families was an undetermined figure as the total number of allowances paid in respect to any soldier is limited to three, although many families are considerably larger. As additional units are still being raised, it can be anticipated that the number of accounts will be considerably increased as time goes on.

In response to requests from a number of hospital associations the Canadian Hospital Council has taken up with the Department of National Defence the possibility of setting up some form of nation-wide group hospitalization for soldiers' dependants. Undoubtedly this would be an ideal arrangement, both from the viewpoint of the dependants who would thus be saved from the burdensome cost of hospitalization and also from the viewpoint of the hospitals. The honourable Minister, however, has definitely stated that such an arrangement for a compulsory deduction is out of the question. It is pointed out that no industrial firm would make such a deduction from its payroll without the consent of those involved and the government could hardly act otherwise. Although the small amount which would have to be deducted from the allowances each month would be inconsequential in view of the benefits to be obtained, one can foresee that there might be criticism from some of the less far-seeing individuals involved, and some political capital might be made out of such criticism. There would also be some cost to the government in organizing the administrative detail, although again this should not be out of proportion to the benefits to be derived from such a plan. It has been suggested by the honourable minister that public bodies in the large centres should get behind local group hospitalization plans and encourage participation by soldiers' dependants. The Dependents' Allowances Board would be ready, it is stated, to

co-operate by supplying lists of dependants who could then be canvassed in the same way as wage earners. This would help those dependants who are in centres with hospitalization plans, provided, of course, that the plans would be willing to take the risk of enrolling dependants without the breadwinner, a departure which, from a morbidity standpoint, has definite risks. It would not help those dependants who do not live in such localities and who are definitely in the majority.

The alternative suggestion has been made that paymasters might be authorized, on request of any hospital, to make deductions to pay for the hospitalization of dependants and also that paymasters should be authorized to honour an order to a soldier for deductions to pay for hospital service rendered to dependants. This suggestion has not been looked upon with favour by Ottawa. At the March meeting of the Executive Committee of the Canadian Hospital Council, it was agreed that the Dependents' Allowances Board should be requested in forwarding pay envelopes to dependants to insert a note pointing out that neither the government nor the municipality should be considered responsible for the hospitalization of soldiers' dependants, that the monthly allowance cheque was designed to cover the usual living and other expenses of the dependants including hospitalization, and that an ideal way of minimizing the burden of any hospitalization costs would be to endeavour to become members of a group hospitalization plan should such be operating in that particular community. Undoubtedly the best solution for this problem from the viewpoint of both the dependants and the hospitals would be a nation-wide plan for hospital care, but until public opinion would seem to have sufficiently crystallized to make such feasible, the above suggestion by the Minister, inadequate though it be, would seem to be the only alternative available.



## *A.R.P. and The Hospitals*

**I**T IS fitting indeed, that the leading article of this issue should deal with Air Raid Precautions as applied to hospitals. So far our coastal cities have not been raided, either from the water or from the air, but with an "all-out" blitzkrieg facing the British Empire this summer, it is high time that more thought was being given to this subject. Recent German flights over Ice-

land and the fact that it would be no feat at all for a German sea clipper to fly over large parts of Canada should indicate the necessity of preparing for emergencies, not only in our coastal cities but in cities further inland. As Major Rogers points out any aerial attack would likely be with incendiary bombs as these are small and light and apt to be more effective in proportion to their weight than high explosive bombs.

It is encouraging to note from the comprehensive report on A.R.P. arrangements in the Maritime hospitals submitted to the Canadian Hospital Council by Miss Ruth Wilson, that so many hospitals in the Maritimes have gone to considerable pains not only to protect their own patients and building, but to provide accommodation for local casualties. It is not so encouraging, however, to note from the replies received that the preparations made in some of the hospitals have been far from adequate and that a number of the hospitals, even in exposed areas, are still complacently presuming that "it cannot happen here". Correspondence from the Pacific coast would indicate that the hospitals could do much more than has been done to prepare for emergencies. With the Japanese situation very much in the balance, it is high time that hospitals give full support to the A.R.P. officials, but, as one key person has stated "the problem has been present for so long that I think we are inclined to be a little too indifferent about the future".

Not only is it important that hospitals in coastal cities work out plans for local and nearby disasters, but hospitals further inland should be giving some thought as to what they should do should casualties closer to the sea become so numerous that it would be necessary to evacuate large numbers to hospitals further inland. Hospitals could well take stock of their available facilities including an ample supply of extra bedding and dressings for traumatic cases.



## A Double Loss

**W**ITHIN the past month the hospital and medical fields on this continent have lost two great leaders—one stricken in his prime, the other in the twilight of a long and notable career.

The whole hospital world was shocked when word was flashed on March 28th of the death of Doctor William Henry Walsh of Chicago, the noted hospital consultant who succumbed despite a serious operation some days earlier. For a number of years Doctor Walsh has been one of the outstanding hospital consultants on this continent and many Canadian cities from coast to coast owe the basic features of the planning and the organization of their fine hospitals to his great genius. Of two Canadian hospitals he was particularly proud—St. Mary's in Montreal and the Saint John General Hospital. Doctor Walsh has long taken an active part in convention work; quick in thought and action, and eloquent in word, his Irish nature led him always into the thick of any discussion—and he almost always carried his point. As a teacher he has had few equals, as those who have attended the Chicago Institute for Administrators and

other seminars and have been enthused by his kindly interest can well attest.

Born in Philadelphia 59 years ago and educated there, Dr. Walsh held high governmental posts in the Philippines, going through the insurrection in '99 and 1900, and later was director of various governmental and civilian hospitals in the United States, in South America and in Central America. At one time he was medical director of the Laurentide Paper and Power Company at Grand Mere, Que. During the last war he commanded a base hospital in France. Twice, once during the Great War and again in 1924-28, he was Secretary of the American Hospital Association. Few indeed, if any, of his contemporaries have had expert knowledge in so many phases of hospital work as had Doctor Walsh.

Doctor David Low of Regina was another doughty fighter. Well over his allotted span, he had been more or less retired for several years, when he passed away peacefully in his sleep on March 9th. For several years Doctor Low was superintendent of the Regina General Hospital and always took a close interest in the welfare of that institution.

Born in Thrums, Scotland, Doctor Low first began to practise in the west over fifty years ago (1890). At that time Regina was the capital of the North West Territories and to that thriving town went the young doctor, where he paid a dollar to sleep on a boarding house floor wrapped in his own blanket. Doctor Low always took great delight in recounting the experiences of those pioneer and interesting "horse and buggy" days. Rugged, honest, plain spoken, ready to state his convictions and just as ready to blast that which was unworthy, "Davey" Low was always the "stormy petrel" at medical meetings yet his inherent sincerity of purpose and his high ethical standards were so recognized that he was honoured with the presidency of both the Saskatchewan and the Canadian medical associations. He, too, was a man whom his colleagues will always remember with the utmost respect and affection.



## Let Every Man Fulfil His Own Tasks

**S**O MANY people are feeling, in these days of tremendous national happenings, that their lives are of so little value to the British cause, and that, if only they had the chance, they could do so much more before their little span is over.

It is well to remember what Epictetus has to say on the subject of service to one's country.

"It is enough", says this great philosopher, "if every man fulfils his own task. And if thou hast made one other pious and faithful citizen for her, art thou, then, of no service to thy country?"

Paraphrase this statement a little—say: "If you have helped to give back health to one citizen, or prevented a child from suffering, or saved it from sickness by helping a prenatal clinic, or given a holiday and nourishing food to someone when needed, or brought gladness and ease from pain to one single man or woman, you are then of service to your country."

—The Australian Hospital.



# National Hospital Day Applicable to Both Large and Small Communities

**N**ATIONAL Hospital Day observance can be adapted to suit communities of any size. Naturally, it is easier to arouse community enthusiasm in smaller centres, but programmes have been highly successful in the large centres. The difference is simply that emphasis is placed primarily upon publicity of a general nature rather than upon the personal contact.

An example of a successful Hospital Day is the experience of Detroit last year. Hospital workers in Canada will be particularly interested because the secretary of the committee and one to whom a large share of credit for the success was due was Mr. Carl Flath, formerly of Toronto. This committee staged one of the biggest publicity campaigns ever conducted in that city. The Mayor issued a special proclamation proclaiming National Hospital Day which was given widespread publicity and followed this up with a radio announcement on the evening of May the 11th. Leading merchants set up striking window displays. One large downtown store had a huge electric sign, fifteen feet by forty feet, outside the building announcing:

"Sunday May the 12th is National Hospital Day. 'Open House' is being held at every hospital. Visit one."

The leading billboard advertising



company contributed thirty-six full size billboard displays for the entire preceding week and the company controlling the street car advertising inserted five hundred standard size cards in various street cars and buses.

The Board of Commerce sent literature to 225 Detroit merchants urging co-operation and assistance. Further literature was sent out later by this organization to 300 selected merchants.

All of the radio stations in Detroit were exceedingly generous. Eight

radio programmes were given over to National Hospital Day. The broadcaster for the Detroit "Tigers" in broadcasting three games repeatedly contributed "plugs" in support of National Hospital Day. During the Saturday afternoon broadcast, he drew attention to the fact that 18 army planes flying in formation over the city were circling the 36 hospitals in greater Detroit participating in the observance.

Every one of the 615 checker taxis carried a 6 by 20 inch sticker on the three preceding days. Thousands of bumper cards, automobile stickers and National Hospital Day poster cards were distributed.

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The small United Church hospital at Ethelbert, Manitoba, observed National Hospital Day for the first time. From all directions came the mothers whose babies were born in the hospital during the past year. The doctor vaccinated twenty free of charge; health posters, made by the school children, were exhibited and prizes given. Then the Ukrainian Ladies' Aid, a community organization, served lunch to over sixty people. Two women spoke, one in English and one in Ukrainian, on "What the Hospitals Mean in the Communities They Serve".



# Canadian Hospital Council to Meet in Montreal in September

## Mid-winter Executive Meeting Covers Large Agenda

**A**RRANGEMENTS are being made for the Canadian Hospital Council to hold its regular biennial meeting in Montreal next September, probably on the 10th and 11th. This decision was reached at a meeting of the Executive Committee held at the Faculty Club in Montreal on March the 7th. Those present were: Dr. George F. Stephens, president, Rev. H. G. Wright, J. H. Roy, Dr. A. F. Anderson, R. F. Armstrong and Dr. Harvey Agnew. Dr. A. K. Haywood was unable to attend.

In consideration of train arrivals from the west, it was agreed that, in September, the Council should convene after luncheon on the first day, carry through an evening session and continue during the following day. An executive meeting will probably be held on the first morning.

The pool for travelling expenses which proved so successful in previous years will again be arranged.

### Hospitalization of Soldiers' Dependents

Considerable discussion took place over the proposal for a nation wide plan of hospital care for soldiers' dependants. From many parts of Canada communications have been received urging the adoption of such a plan and many hospitals have voiced protest over the increasing tendency for dependants to assume that their accounts would not have to be paid by themselves. Correspondence with Ottawa was read indicating that the government is not prepared at the present time to institute such a plan. An alternative suggestion from New Brunswick that Ottawa be asked to give authorization to the unit paymasters permitting non-resident soldiers to assign portions of their pay to hospitals for the care of dependants has not received approval at Ottawa. The Department of National Defence has suggested that dependants should be encouraged to join local hospital care plans. While this suggestion would at the most be of service to

only a portion of the dependants, it was agreed that the Dependents' Allowances Board should be requested to insert a note in the cheque envelope of each dependant suggesting that the recipient inquire about the possibility of joining a local plan (should dependants without a breadwinner be eligible for membership) and that this note should also point out that the dependants are expected to pay their necessary hospitalization out of their allowances. It was agreed also that the various group hospitalization plans should be approached to see if soldiers' dependants could be made eligible for membership.

### Importation of Equipment

The effect of the War Exchange Conservation Act on the importation of equipment was reviewed. The new regulations have prohibited the importation of some articles and have added materially to the cost of others. The obvious necessity for conserving foreign exchange and for increasing the revenue of the country was recognized. It was agreed that where the prohibition of imports or the placing of a special impost on importations from non-sterling countries was likely to seriously handicap the work of hospitals, such situation should be protested but, in view of the serious situation now being faced by Ottawa, it was agreed that such regulations should not be protested if the amount involved were of little consequence or if the product could be obtained without these extra tariff impositions from Great Britain.

### Hospitals and the War

The recent survey of facilities in civilian hospitals available to the government in case of national emergency was reviewed. Although the likelihood of errors in the replies was obvious, it was agreed that this report is probably the most reliable summary available at the present time. The government has expressed

keen appreciation to the Council for the information contained therein. It was agreed that a summary of the study of A.R.P. measures in the Maritime provinces should be published if authority be obtained.

Enlistment of interns and the arrangements for postponement of military training were considered. All hospitals likely to have interns have already received information relative to the present desire of the government not to disturb the interns during their first year of internship if at all possible. It would appear that hospitals have not had difficulty in adjusting training periods for young men in key positions.

V.A.D. training in hospitals has not as yet been officially requested by either the Canadian or the British government. It would seem to be entirely a matter for each hospital to decide whether or not it desires to provide practical training in nursing for local groups of certificate holders who desire to take further work even though there is no likelihood at the present time of their services being needed. (See article in this issue.)

As it is quite possible that hospitals will receive requests for increased facilities for the training of laboratory and radiological technicians, for internships for physiotherapists, for facilities for the training of medical anaesthetists for the army, and for refresher courses for nurses and others, the Executive Committee agreed that the Council should encourage hospitals to give this assistance to the country whenever a legitimate request for such training be made.

The large number of military, air force and naval hospitals being erected throughout the country has given rise to some concern from the viewpoint of national economy. It is understood that in the neighbourhood of 100 hospitals of varying sizes have been set up, most of these being of a distinctly temporary na-

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# Hospital Purchasing Standards in Canada

## Should we Develop our Own Standards?

To the Editor:

Reference is made in the March issue, page 70, to a "Manual of Specifications for the Purchase of Hospital Supplies and Equipment", issued recently by the American Hospital Association. Apparently this manual gives specifications for the purchase of most articles used by hospitals. Have we any comparable compilation in Canada? Is it not possible that specifications for Canadian requirements would vary somewhat from those contained in this manual?

Yours very sincerely,

—Purchasing Agent.

THE manual to which reference was made in the March issue was prepared by a Special Committee on Simplification and Standardization of Hospital Furnishings, Supplies and Equipment of the American Hospital Association and was based in large measure upon standards set up by the National Bureau of War, the Department of the Navy and the Veterans Administration. It is essentially a compilation of standards as they have been developed in the United States.

The A.H.A. Manual is well worth having in any hospital purchaser's library. Even if some of the specifications are not suitable for Canadian trade conditions there are many (possibly the majority) which are. These are the specifications for goods which are:

- (a) ordinarily made in the United States
- (b) imported from other countries through dealers in the United States
- (c) made in Canada but chiefly by firms which are now branches of U.S. firms or have been first established as branches of U.S. firms

On the other hand there are many supplies which are bought by considerations of economy or national policy from sources other than those from whom the American hospitals would buy. Certain items we buy are manufactured in this country and others are imported from Empire sources. To use U.S. specifications in the purchase of these items

might in many cases bar quotations from our most useful sources of supply.

In Canada no such general compilation of standards and specifications has been made. Individual items, however, have been subject to official definition and certain commodity standards have been prepared by the Canadian Government Purchasing Standards Committee. This is an interdepartmental body, sponsored by the National Research Council, and, although the use of its standards by government departments is not mandatory, the publications of this committee have received wide acceptance. These standards include specifications for soaps, tex-

tiles, clinical thermometers and disinfectants of the coal-tar type. It is expected that specifications for hospital rubber sheeting and hot water bottles will be ready for issue in the near future.

In addition, this committee has prepared specifications on various kinds of paints and pigments, on metal polish, on lubricants and various liquid fuels, on stationery forms, on paper quality, on refractories (fire-clay, boiler cement, etc.), safety-glass, road materials, coal, anti-freeze and other substances. We are informed by the National Research Council that copies of these specifications may be obtained from its Acts

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## Could There be a Compilation of Canadian Standards?

To the Editor:

The Manual of Specifications issued by the American Hospital Association is a most valuable one and should be closely studied by all making hospital purchases. However, it cannot be applied to all purchases by Canadian hospitals, as many of the articles purchased here follow essentially Canadian specifications or are imported from Great Britain or elsewhere.

It would seem desirable, therefore, that there should be a compilation of specifications suitable for Canadian hospitals. Knowing that the cost of printing such a compilation in one volume might be a bar to its ready use I would like to make the following suggestion.

The Canadian Hospital Council could appoint a committee to compile a list of specifications suitable for Canadian hospital use. This committee would draw first from such Canadian specifications as are available, then from such British and United States specifications as may be applicable. A list of such specifications could then be published in much the same form as the supplemental index on pages 699-713 of the A.H.A. Manual, setting forth where

each specification may be obtained and its cost. Many food specifications could be obtained free from the Dominion Department of Agriculture. I presume the National Research Council specifications may be obtained from its Acts and Specifications Section for a small fee comparable to that charged by the Superintendent of Documents in the United States. A loose leaf binder might be prepared to hold individual specifications not already contained in the A.H.A. Manual. The cost of the binder plus the cost of the individual specifications should not prove excessive and could be paid by the individual hospitals desiring to use the compilation. The publication of the list of specifications suitable for Canadian hospitals would at least inform Canadian hospital purchasing agents where proper specifications could be obtained.

I agree with you entirely that purchasing should as far as possible be done to specification. It is the only way fair to the hospital and its suppliers.

Yours sincerely,

(Sgd.) John Horal

Purchasing Department  
Toronto Western Hospital.

The CANADIAN HOSPITAL

## Suggested Menus for Public and Semi-Public Patients

Prepared under the direction of  
*Ethel C. Pipes, Director of Dietetics,*  
*Vancouver General Hospital*

Breakfast	Dinner	Supper
Rolled Oats Eggs Toast—Marmalade Tea—Coffee	Vegetable Soup Roast Beef with Gravy Mashed Potatoes Diced Butter Carrots New Apple Pudding with Lemon Sauce	Cream of Lima Bean Soup Cold Meats Baked Potatoes Lettuce Plums
Light Diets	Vegetable Scallop	Cold Lamb
Rolled Wheat Bacon Toast—Marmalade Tea—Coffee	Split Pea Soup Broiled Breaded Liver with Gravy Whole Potatoes Buttered String Beans Creamy Rice with Raisins	Cream of Tomato Soup Codfish Loaf with Egg Sauce Combination Vegetable Salad Rhubarb
Light Diets	Scrambled Eggs on Toast	Same
Oatmeal Eggs Toast—Marmalade Tea—Coffee	Scotch Broth Beef Stew with Mixed Vegetables Steamed Potatoes Cottage Pudding with Fruit Sauce	Cream of Vegetable Soup Italienne Spaghetti Lettuce Hearts with Dressing Peaches
Light Diets	Lamb Fricassee	Spaghetti with Tomato
Cream of Wheat Bacon Toast—Marmalade Tea—Coffee	Bouillon Roast Lamb with Gravy Mashed Potatoes Peas Caramel Date Pudding	Cream of Corn Soup Shepherds Pie with Gravy Waldorf Salad Apricots
Light Diets	Lima Bean Souffle	Same
Rolled Oats Eggs Toast—Marmalade Tea—Coffee	Macaroni Soup Steamed Fresh Salmon with Pickle Sauce Boiled Potatoes Harvard Beets Apple Crisp	Cream of Potato Soup Cheese Souffle Perfection Salad Stewed Figs
Light Diets	Steamed Cod with Sauce	Same
Rolled Wheat Bacon Toast—Marmalade Tea—Coffee	Vegetable Soup Braised Tongue Mashed Potatoes Cubed Parsnips Lemon Snow with Sauce	Cream of Pea Soup Scrambled Eggs on Toast Lettuce Hearts with Dressing Pears
Light Diets	Creamed Tripe	Same
Oatmeal Eggs Toast—Marmalade Tea—Coffee	Rice and Tomato Soup Roast Beef with Gravy Creamed Cauliflower Mashed Potatoes Delicious Rhubarb Pudding	Cream of Vegetable Soup Cold Ham Scalloped Potatoes Pickles Baked Apples
Light Diets	Extra vegetable— Carrots	Cold Lamb Lettuce Hearts with Dressing

(Menu for Second Week following page)

### Whole Wheat vs. White Bread

White flour is made by grinding the endosperm of the wheat berry to a fine powder, the outer layers being removed. . . . In patent flours the fat content is about one-half and the ash content about one-sixth of that found in whole wheat. . . . Various workers have shown that in the modern process of milling the biological value of wheat protein is lowered for nitrogen repair as well as for growth of animal organism. The evidence for the relative availability and digestibility of the carbohydrate of whole wheat and white flour is somewhat conflicting. The reduction of the iron content of the whole berry to one-fifth of its amount in patent flour is probably very serious. The vitamin C and D content of wheat and wheat flour is nil. The amount of carotene in whole wheat is enough to be of value, but it is largely lost during milling and the small amount that survives in flour after milling is destroyed during the bleaching process. The vitamin B (complex) content of the wheat seed is considerable. It has been thought for a long time that the whole of the vitamin B complex of the wheat berry was contained in the embryo and outer layers, and that the endosperm and therefore the white flour made from it were devoid of these factors. . . . They (Copping and Roscoe) found, however, whole-wheat bread to contain 0.95 (0.75-1.3), "brown" bread 0.6 (0.5-0.8), and white bread 0.22 (0.12-0.30) units per gramme. The flavin content of white flour is about a half of that of whole-meal flour and is partly destroyed during storage. Whole-wheat flour contains vitamin E, but white flour almost certainly contains none. Thus the more exact information on the nutritive value of whole-wheat and white flours made available by more accurate methods of determination fully confirms the earlier impression of the really serious inferiority of white bread as compared with whole-meal bread in every criterion of nutritive value so far adopted.

From an abstract of a B.M.J. editorial in *The National Health Review*.

### Cobalt Hospital Closes Doors

The Municipal Hospital at Cobalt, Ontario, has closed down because of financial difficulties.



**Public and Semi-Public Menus**  
(Continued from preceding page)

Breakfast	Dinner	Supper
Cream of Wheat Eggs Toast—Marmalade Tea—Coffee	Vegetable Soup Meat Loaf with Gravy Boiled Potatoes Stewed Tomatoes Apricot Cobbler	Cream of Potato Soup Beefsteak and Kidney Pie Lettuce Hearts Pears
<b>Light Diets</b>	<b>Special Meat Loaf</b>	<b>Lamb Pie</b>
Rolled Oats Bacon Toast—Marmalade Tea—Coffee	Split Pea Soup Pot Roast Mashed Potatoes Baked Squash Spanish Cream	Cream of Corn Soup Macaroni and Cheese Waldorf Salad Peaches
<b>Light Diets</b>	<b>Extra vegetable—beets</b>	<b>Same</b>
Oatmeal Eggs Toast—Marmalade Tea—Coffee	Scotch Broth Baked Cod with Hollandaise Sauce Baked Potatoes Peas Chocolate Blanc Mange	Cream of Vegetable Soup Cold Meats Potato Puff Beet and Celery Salad Stewed Prunes
<b>Light Diets</b>	<b>Same</b>	<b>Cold Lamb</b>
Rolled Wheat Bacon Toast—Marmalade Tea—Coffee	Bouillon Roast Beef with Gravy Mashed Potatoes Diced Parsnips New Bread Pudding	Cream of Tomato Soup Cottage Cheese Salad with Hard Cooked Eggs Baked Potatoes Applesauce
<b>Light Diets</b>	<b>Scrambled Eggs</b>	<b>Same without hard cooked Eggs</b>
Rolled Oats Eggs Toast—Marmalade Tea—Coffee	Macaroni Soup Spanish Steak Boiled Potatoes Sliced Carrots Fruit Jelly	Cream of Vegetable Soup Corn Scallop with Bacon Lettuce Hearts with Dressing Loganberries Vegetable Scallop with Bacon
<b>Light Diets</b>	<b>Spinach Souffle</b>	
Oatmeal Bacon Toast—Marmalade Tea—Coffee	Vegetable Soup Roast Lamb with Mint Sauce Boiled Potatoes Buttered Beets Fruit Trifle	Cream of Lima Bean Soup Assorted Cold Meats on Lettuce Creamed Diced Potatoes Stewed Plums
<b>Light Diets</b>	<b>Tomato Scallop</b>	<b>Cold Lamb</b>
Cream of Wheat Eggs Toast—Marmalade Tea—Coffee	Rice and Tomato Soup Baked Ham with Gravy String Beans Mashed Potatoes Prune Whip with Custard Sauce	Cream of Carrot Soup Finnan Haddie Cooked in Milk Mashed Potatoes Lettuce with Dressing Apricots
<b>Light Diets</b>	<b>Bacon</b>	<b>Same</b>

Recipes will be forwarded upon request.

**Saskatchewan Clinics Change Location**

The minister of public health has announced that venereal disease clinics of the province of Saskatchewan, now situated in office buildings at Saskatoon, Regina, Moose Jaw and Prince Albert, are to be

moved to hospitals located in these cities. In Saskatoon the clinic has already been moved to the City Hospital, where it will operate as an out-patient department of the hospital, although still under the direction and control of the department of public health.

**Hospital Purchasing Standards**  
(Continued from page 32)

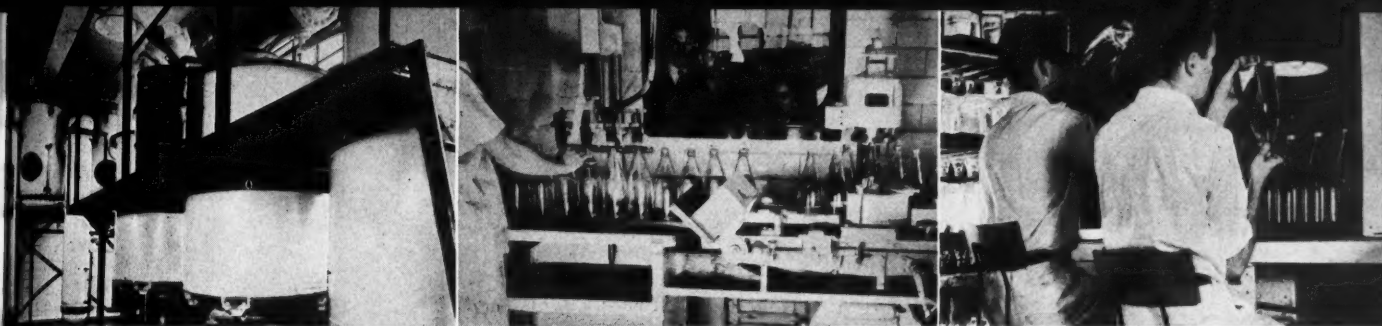
and Specifications Section. Recently the same organization has worked out a very fine National Building Code, which provides specifications for all aspects of construction.

The Canadian Engineering Standards Association at Ottawa has been instrumental in setting up fine standards for electrical work in Canada. The army, the Department of Pensions and other governmental bodies have supplemented the National Research Council specifications with their own standards for purchases of a number of hospital commodities. Many of our manufacturers, too, have followed the suggestions of the American College of Surgeons and other bodies in reducing the number of sizes and types of gauze, beds, etc.

We in Canada are in an unusual position with respect to standards. Linked by tradition and instinct with Great Britain, we have long had a close contact with the standards of mensuration and quality developed by Great Britain for its local and empire trade. On the other hand, our close proximity to the United States and the tendency for so many of our institutions to purchase equipment either from the United States or of a design which originated there, has resulted in a very definite tendency to follow standards developed in the United States. For instance, American standards for gauze and canned goods are largely followed in Canada.

In many respects the American and British standards tend to be similar. For instance, both American and British standards require that beds shall be 78 by 36 inches in size and the height from the spring bottom shall be 27 inches. In the case of double coat rubber sheeting, however, it is noted that there is some variation; the British specifications stipulate the necessary warp and weft count of the cotton fabric, but this is not given in the American standard. British rubber sheeting must have a tensile strength in both warp and weft of 85 pounds per inch, whereas the American standard requires but 55 to 65 pounds, according to thickness. The British standard requires that the thickness shall be between 0.035 inches and 0.039 inches; the American standard

(Continued on page 38)



1. The equipment for the preparation of litre solutions. These tanks are carefully sterilised with live steam as soon as each lot is completed.

2. Air in the litre solution filling room is kept constantly pure by filtration through the oil film.

3. Containers are all inspected individually to discover the presence of any foreign matter.

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Intravenous solutions are furnished in the Abbott Container, a bottle specially designed to resist high steam pressure sterilization. Its outer protective seal gives positive assurance of sterility. The inner cap is easily removed by the fingers, without danger of contaminating the lip of the bottles. When the cap is removed, there is no inrush of air to carry spores of air-borne bacteria or molds. Moreover, there is no rubber contact with the solution—no "rubber" odor or taste.

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4. The absence of pyrogenic effect in every lot of Abbott intravenous solutions is demonstrated routinely by intravenous injection of samples of the solutions into rabbits, the rectal temperature of the animal being taken every hour before and after the injections.



5. Following final sterilization, intravenous solutions are again inspected under strong light for foreign particles.

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# Here and There

## Health Insurance vs. State Medicine

**I**N AN effort to clarify many misconceptions concerning what is meant by "medical economics" and to establish basic principles which should underly any discussion of this subject, a series of pamphlets is now being issued by the Committee on Economics of the Canadian Medical Association. These have been written primarily for the intern and young practitioner, as it is realized that the practice of medicine is likely to undergo radical changes in the next decade or two, thus making these questions of paramount personal concern to the practitioner now entering upon his professional career.

Bulletins One and Two have already been issued to the interns of all approved or commended hospitals and Bulletins Three and Four will follow shortly. It is hoped that the interns, with the assistance of staff doctors interested in the subject, will hold regular evening or luncheon discussions on medical economics, using these pamphlets as a basis for discussion. Next fall and winter it is hoped to issue six or more additional bulletins at monthly intervals, thus permitting the interns and staff members to develop their knowledge of medical economics by regular periods of study. Any semblance of propaganda favouring any particular conception of health insurance is being avoided by the Committee as its sole objective is to furnish the oncoming generation of doctors and others interested with an impartial analysis of this subject and of its various experimental approaches and solutions.

Staff doctors, trustees, administrators or others desiring copies of these bulletins may obtain such by writing to 184 College Street, Toronto.

## Kingston General Issues Bulletin

Kingston General Hospital has just issued its first Information Bulletin which is to be a monthly feature. The bulletin, a mimeographed sheet, will go to the governors, the Women's Aid and donation subscribers. It tells how the donation fund has been spent and carries news items as well.

## Where Men are Men

The fine account of themselves which the Texas volunteers in our air force are giving recalls to mind a story which we first heard down in that "Lone Star" state from a giant of a Texan who recounted the tale with much more vivid language than we dare use in these columns.

It seems that one hot summer evening, the loungers in a sleepy Arkansas town were startled to see bearing down on them in a cloud of dust a long lean ranch hand, obviously a Texan (Texans always seem to be "lean") riding a rattling contraption drawn by two foam-flecked mountain lions and vigorously wielding a live rattlesnake as a whip. Drawing up at the town hitching post, he stuck his "riding whip" into his pocket and stalked into the saloon.

"Wan' some likker?" asked the bar keeper. "Nuthin' stronger?" returned the stranger.

"Wal," drawled the bar keeper, backing away, "I got some carbolic acid and you can take some sulphuric acid for a chaser." "Okay, pal, lay it down."

Three snorts neat went down, just like that!

"Say, stranger, where you come from in Texas?" "Devil's Canyon", the stranger snapped.

"Why 'dja leave?"

"Got run out", was the surly answer.

"Ya, but why?" asked a bystander in a reckless mood.

Suddenly the fire-eating Texas heman bit his lip. "Wal, you see, they're kind of proud of the reputation of the place and said they didn't want no *sissies* hanging about!"

## Unappreciated Luxury

It seems odd that Germany should be protesting the use of old Fort Henry at Kingston as a camp for German prisoners. Not many people actually have visited this historic old spot at Kingston which is probably as costly an abode for prisoners as is used on either side in this war. Last year in the Ontario legislature, in answer to a question, it was stated

## By THE EDITOR

that the cost of restoring and renovating this old fort amounted to \$831,895. This summer, when most of us will be sizzling in temperatures in the 90's, this "prison" will probably be about the most comfortable place in Eastern Canada.

## Sales Tax on Blood

If our government, which is finding it necessary to raise money from every possible source, hears about what is going on in Colorado, we can envision another application of the sales tax. There it has been ruled that where blood is purchased from a professional donor at a definite commercial price, such sale shall be subject to the sales tax. Were that to apply here, the tax would probably be applicable where the relatives pay the donor for the blood, but would not be applicable where the hospital pays the donor, provided such payment were not passed on to the patient or relatives. As the hospital would naturally anticipate collecting in turn from the patient or relatives where possible, a nice point in interpretation of the ruling would have to be made.

## Physiotherapist Meets Test

The story of the 23-year old Canadian physiotherapist who was acclaimed by all London as a heroine after the tragic bombing of the Cafe de Paris, in which four Canadians lost their lives, is one of which Canadians may well be proud.

We have sometimes wondered whether it takes a special breed of men to stand up to the horror of to-day's warfare as waged by the Nazis, but if the behaviour of those Canadians who have come "under fire" is typical, we need have no fears regarding the morale of our own people.

Such utter disregard for her own safety and comfort, as was shown by Miss Stevens when she proceeded to help in rescue and first-aid work after extricating herself from the wreckage about her, is an inspiring challenge to members of her profession who in this war are recognized as a part of the Royal Canadian Army Medical Corps.

The CANADIAN HOSPITAL.



# Specify "BASSICK"

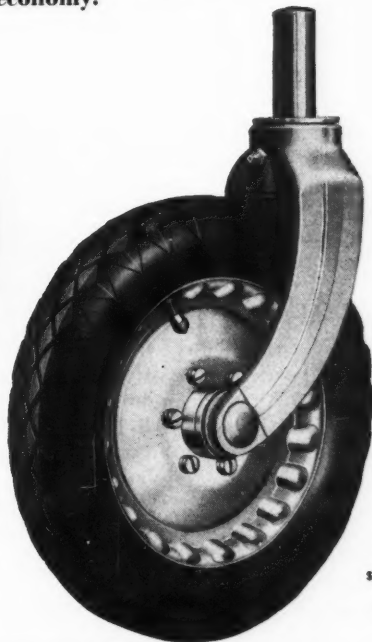
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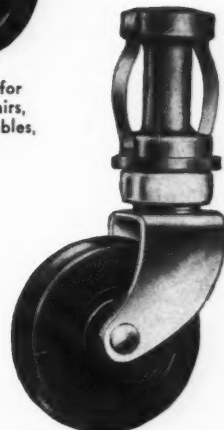
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## Lydia, the "Woman's Friend," Again in the Limelight

IN THE past few weeks the press has carried several references, some at considerable length, to the story of Lydia Pinkham and her famous compound for all that ails the female of the species. This may have been stirred up by recent litigation, the result of prolonged family differences, or perhaps to a sudden revival in the sales of this miracle-working panacea. It is a remarkable story of how fortunes can be made by capitalizing on the willingness of the masses to believe anything in print, especially if it relates to health and, in particular, to delicate complaints mainly discussed at quilting bees.

The story has been recorded at length. The legendary Lydia was not really fictitious, like so many of the bewhiskered gentlemen who have adorned patent medicine labels. She was born Lydia Estes in 1819 in Lynn, Mass., Pinkham being her married name. When the family fortune was lost in the crash of '73, Mrs. Pinkham turned to brewing and selling a concoction for female complaints, then the favourite refuge of women of that unsettled Mid-Victorian era. It is hard to say whether initial credit should have gone to George Todd who contributed the recipe as payment of a debt, or to the buggyload of women who drove over from Salem to buy some of this medicine, thus giving Lydia the idea. Extravagantly worded advertising, subject to no public-protecting restrictions in those days, soon made it a household remedy wherever women had tired backs (and who didn't?) or thought they had "kidney trouble" or "female weaknesses".

Like Mrs. Eddy who took the writings of Quimby and shrewdly applied his knowledge of the powers of suggestion to the building up of a great cult, Lydia Pinkham and her family, with equal shrewdness, capitalized on those features likely to appeal to the uneducated. The "vegetable" and, therefore, harmless nature of the concoction was emphasized. Her "fan mail" brought in thousands of eulogistic letters; to the authors of the more usable letters she is said to have sent a dollar to

have a picture taken for publicity purposes. For a long period 50 per cent of the income was turned back into advertising; the popularity of the compound has varied with the advertising activity. The product has had several changes in composition and its history has been a long succession of family squabbles and litigation.

In the early days anything in the nature of claims went. In 1876 it was "A sure cure for prolapsus uteri, or falling of the womb and all female weaknesses", obviously a ridiculous and wholly unscientific assertion. Slowly over the years, government regulations have curbed the wild claims of charlatans and others. Now the label mildly states that this product is "Recommended as a vegetable tonic in conditions for which this preparation is adapted". You can interpret this as you will, depending upon your degree of scientific knowledge and upon your credulity. As Dr. A. J. Cramp of the A.M.A. Bureau of Investigation has remarked, "This statement is about as informative as it would be to say that 'For those who like this sort of thing, this is the sort of thing that those people like'".

The composition of the nostrum according to a report of chemists of the British Medical Association made some years ago revealed it to contain 19.3 per cent by volume of alcohol and only 0.6 per cent of solid substances. No alkaloid was present and no evidence was obtained of any active principle, except a trace of a bitter substance soluble in ether. According to S. H. Adams, author of the series of articles in *Colliers* on "The Nostrum Evil," "Lydia Pinkham's variety of drink depends for its popularity chiefly on its alcohol".

Now the product is compelled to state its ingredients. These are now 15 per cent alcohol and a list of mild drugs, most of them no longer mentioned in medical schools, which are commented upon by the *Journal* of the A.M.A. in its May 20, 1939 issue. Vitamin B<sub>1</sub> has been added, though the question is raised whether or not a preparation con-

taining 15 per cent alcohol would help a person needing vitamin B<sub>1</sub>, (vitamin B<sub>1</sub> is often deficient in persons taking alcohol). *Gentian* is a recognized bitter. *Black cohosh* "has not been found to possess definite value". *True unicorn* (*aletris* N.F.) is "without evidence of value". *False unicorn* (*helonias* N.F.) is "without established value". *Lif-root* is no longer included in official compendiums and "is entirely superfluous". *Pleurisy root* "is described as 'an absolute domestic remedy . . . Probably without value'". *Dandelion* appears in the National Formulary as *taraxacum* and has been used as a bitter and as a mild laxative. *Chamomile* is listed as *matricaria* and has been used as a bitter, tea, or poultice; "the effects, if any, are due mainly to hot water".

### Hospital Purchasing Standards (Continued from page 34)

gives thicknesses for double coated sheeting of .020 and .025 for standard grades, and of .008 for high grade. British sheeting is 26 ounces per square yard, whereas American sheeting is, for the high grade type, 6, 10 and 14 ounces, depending upon the thickness of the cotton fabric.

The increasing manufacture of products for use in England by the United States will have a still further effect in gradually unifying our specifications. It would seem advisable that purchasing agents should be familiar with Canadian, American and British standards. The essential point is that some standard should be followed, not only to ensure good quality, but to permit duplication at a later time. Those standards should be followed which would best meet the needs and would permit the product purchased to be used in conjunction with other products being purchased at the time or in the future.

—Editor.

### Naming of New Fort Frances Hospital Honours Historical Figure

The new hospital to be operated by the Sisters of Charity at Fort Frances, Ontario, will be known as LaVerendre Hospital in honour of the man who established the first white man's camp within the boundaries of that town.

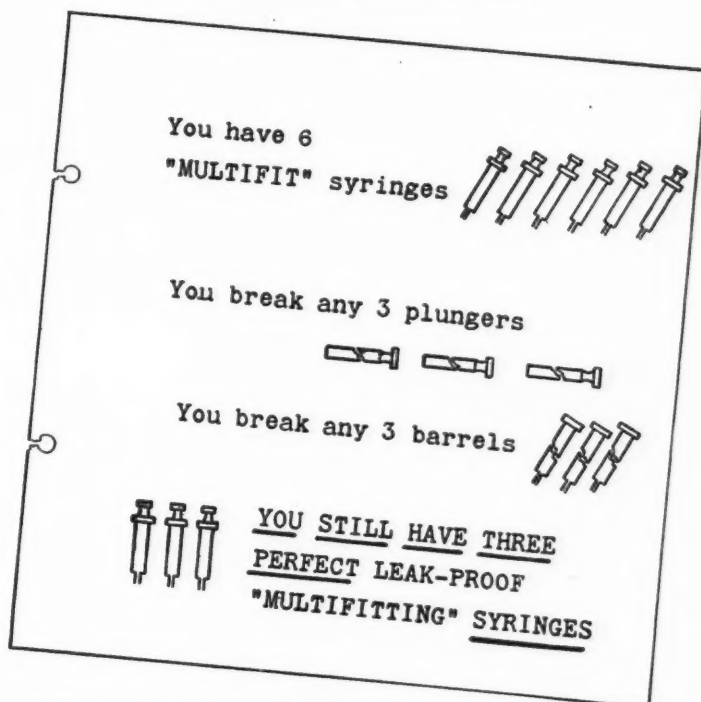
The CANADIAN HOSPITAL



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# Check List of Hospital Hazards

A CHECK list of hazards has been included in the Manual on Insurance for Hospitals, which has been prepared by the Committee on Insurance Coverage of the Council on Administrative Practice of the American Hospital Association. This excellent manual reviews various forms of insurance for hospitals and discusses the fundamentals of insurance as it relates to hospitals, which should be understood by anyone having to do with the arrangement of insurance policies on hospital risks.

## I. Physical and Permanent

### 1. General location of buildings, exposures, etc.

- a. Are there any unprotected doors which by accident or intent might be a cause of falls or other injury?
- b. Are there any unnecessary or unused windows opening near other buildings through which fire could spread?
- c. Are there any attractive nuisances (e.g., ponds for children), or hazardous porches, rooftops, promenades, balconies, ladders, open buildings unattended, etc.?
- d. Are there any irregularities of sidewalks, streets, projecting pipes and manhole covers, vent-pipes, oil fill pipes, garden hose, valves, etc., which are dangerous?
- e. Are there any loose parts on buildings, coping, roof, temporary structures, signs, etc., which might fall and cause injury?
- f. Are there any wires, poles holding wires and transformers which may fall or cause dangerous electrical results?
- g. Are there any poorly lighted building entrances, driveways, approaches, signs, etc., which are hazardous to persons in a hurry or to those with poor vision, especially to those who see poorly at night?

### 2. Buildings proper

- a. Are the exits and fire escapes marked and lighted according to law?
- b. Are the stairhalls marked so that

deliberate or accidental falls cannot easily take place?

- c. Are the windows barred or protected where there are irrational or disturbed patients?
- d. Are there proper doors for powerhouse, shops, maintenance buildings, etc., to keep out public and children?
- e. Are there properly vented storage facilities for x-ray films?
- f. Are there fire alarm systems? Are they working? Does the fire department know the location of stations? Are they checked by the fire department periodically?

### 3. Interior of buildings in general

- a. Are the floors too slippery after waxing?
- b. Are there hand rails on stairs and in elevators?
- c. Are corridors cleaned so one side is dry while other is being washed, mopped or waxed? Is such cleaning done at night or during periods of least traffic?
- d. Are there upturned edges of mats, rugs, uneven tile, marble, etc., which might cause injury? Are all rugs treated to prevent slipping?
- e. Are the stair landings lighted properly and are exit lights at all times on separate wiring?
- f. Are housekeeping and painters' apparatus properly stored so as to prevent fire hazards (oily rags, cigarette butts, etc.)?
- g. Are sand urns provided especially in wood floored buildings, outside operating suite area, laboratories, etc?
- h. Do you keep fire extinguishers in operation, test them annually as required by law (using such emptying of extinguishers as method of training personnel to fight fires made and under control of fire department? Are hoses in good condition? Are valve handles in operation?
- i. Are adequate signs provided not only for fire exits but for all exits?
- j. Are double acting doors hinged on side facing direction of corridor traffic to prevent collision injuries?

## II. Conditions and Practices

### Personnel Technique

#### 1. Institution as a whole

- a. Are employees aware of risks? Do they seek to eliminate them? Is there a programme of training, posters, etc? Are periodic safety meetings held?
- b. Are employees' quarters kept in good condition to stimulate sense of importance of good housekeeping and repair?
- c. Are employees' encouraged to refrain from using tools with which they are not accustomed?
- d. Do employees report dangerous conditions, accidents to patients, fumes, smoke, sparks and dangerous conditions?

#### Institutional Systems by Departments

##### 1. Kitchen and Dietary

- a. Is electrical equipment guarded?
- b. Are grinders, slicers and mixers guarded?
- c. Is there grease or soap on floor?
- d. Are there holders for knives and other utensils?
- e. Are handles firmly attached to pots and pans?
- f. Do metal sinks have sharp corners or edges?
- g. Is there grease in stacks or flues?

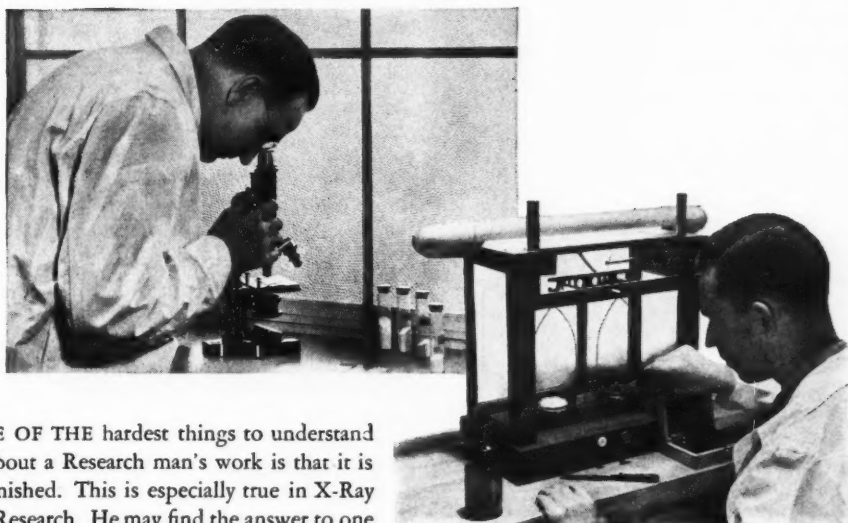
##### 2. Pharmacy

- a. Is rubber hose being used to conduct illuminating gas, steam or chemicals under pressure?
- b. Are approved containers being used for inflammable fluids (benzene, ether, acetone, etc.)?
- c. Is there an approved narcotic control system?
- d. Is there an approved alcohol control system?
- e. Is there a book for recording names, purposes and time of those coming to pharmacy at night for drugs or supplies?
- f. Is there an inventory control for dangerous or expensive drugs and biologicals?
- g. Are all bottles and containers clearly marked and uniform for each item?
- h. Are dangerous and poisonous drug containers so marked?
- i. Is there proper lighting to avoid errors?

(Continued on page 42)

# RESEARCH THAT KEEPS PATTERSON SCREENS AHEAD

KEEPS YOU AHEAD, TOO!



ONE OF THE hardest things to understand about a Research man's work is that it is never finished. This is especially true in X-Ray Screen Research. He may find the answer to one problem about a base chemical—but often that answer simply opens a whole line of new questions which send him off again, on the trail of new developments.

At work in Towanda, developing your X-Ray Screens and guarding their uniform quality, are the trained forces of the Patterson Research and Testing Laboratories . . . studying and improving production machinery, guarding the purity of base materials, checking screen performance and uniformity . . . in a never ending study of what goes on inside your cassette.

Through this close concentration on one problem—the development of better X-Ray Screens—have come such contributions to better diagnosis as:—the first brilliant fluoroscopic screen; the first double intensifying screens; the first

High Speed Screen; and the dependable uniformity of all Patterson products.

Today, among all the variables that must be considered in X-Ray work—such as voltage, amperage, exposure, distance, etc.—the one *constant* you can always count on is the uniform performance of your Patterson screens.

And for the future, developments of the Patterson Research Laboratory will continue to contribute to the further improvement of X-Ray diagnosis . . . constantly pressing toward new horizons for developments which will make available better base materials and finished screens.

THE PATTERSON SCREEN COMPANY  
TOWANDA, PA., U. S. A.

**Patterson** • WORLD'S STANDARD FOR HIGHEST SCREEN QUALITY

### Check List of Hazards

(Continued from page 40)

- j. Are experimental products used without control in treatment of patients?
- k. Is there adequate equipment, e.g., scales and other apparatus for accurate dispensing?

#### 3. Anaesthesia

- a. Are there proper notices (NO SMOKING, OPEN FLAMES, ETC.)?
- b. Are rules enforced controlling smoking and flame hazards, cauteries, heating units, x-ray or diathermy and other sources of electrical sparks?
- c. Is apparatus for anaesthesia and all electrical equipment checked regularly?
- d. Are gas cylinder valves working smoothly (never oiled)? Are there proper wrenches for fittings? Are tanks covered with cloth sleeves (concealed names dangerous)?
- e. Are tank trucks in good condition, easily movable and with low centre of gravity?
- f. Are pipeline systems checked regularly for leaks?
- g. Is there caution against greasy fingers (even from own hair) when connecting regulators?
- h. Are empty tanks marked and stored in a different place from full tanks?
- i. Are all tanks containing gas and other inflammable anaesthetics kept away from radiators, steam pipes, fire, sparks or electrical equipment?
- j. Are measures taken to ensure humidity within gas apparatus before starting anaesthesia?

#### 4. Operating Room (Surgery)

- a. Is there humidity control (hygrometer)?
- b. Are all switches spark proof?
- c. Is mechanical equipment placed outside rooms wherever possible?
- d. Are overhead surgical lamps securely fastened? Are cables on movable lights inspected regularly?
- e. Are operating tables and other equipment and apparatus examined routinely for possible repair?
- f. Are safety holders provided for breaking catgut tubes?

#### 5. Floor nursing equipment

- a. Are chart identifications unmistakable?

- b. Are signal systems working?
- c. Are utensils, dishes and glassware in good condition (no chipped, sharp edges or loose parts)?
- d. Is drug cabinet kept locked?
- e. Are sterilizers, bedpan washers, etc., arranged so that steam burns cannot occur?
- f. Is there non-syphoning (air gap, vacuum breaker) protection on sterilizers, etc?
- g. Is there periodic sterilization of cart containers and contents?
- h. Is there a system of recording and controlling medication lists, treatments, etc?
- i. Are there anti-tips on wheel chairs? Are ramps guarded?
- j. Are radiators, blanket warmers and hot plates protected?
- k. Are there signal lights on all sterilizing equipment and hot plates?

#### 6. Laboratories (Pathological and All Others)

- a. Are there safe containers for dangerous and inflammable materials?
- b. Are there safe tank holders, valves and apparatus for liquid carbon dioxide for frozen tissue work (danger of finger freezing)?
- c. Is there a method of control for specimen identification?
- d. Is there an adequate system for checking blood donors?
- e. Are microscopes insured against theft? Is there a safe place in which to lock them? Are serial numbers recorded for all such equipment?
- f. Are there safety covers on centrifuges? (Top should lock automatically when motor is running.)

#### 7. X-ray Department

- a. Is malpractice insurance carried on radiologist for both x-ray and radium?
- b. Is there an approved system of x-ray filter control and of record keeping?
- c. Is safety film (acetate—not nitrate film) used?
- d. Is nitrate film stored as prescribed by insurance carrier (ventilation, separate room or building)?
- e. Is apparatus shockproof (especially on portable equipment)?
- f. Are there safety controls on

water cooled equipment, for water failure, etc?

- g. Are alarms provided to prevent deep therapy overdose?

- h. Is there a control system so that films do not leave department without permission?

#### 8. Laundry

- a. Are the presses of safety type so fingers and hands cannot be caught?
- b. Are there guards on flat work rollers to protect hands?
- c. What provision is there for ventilation, salt dispensers and similar protection against heat fag?
- d. Are steam lines insulated?
- e. Is there a steam trap for each machine? Is it easily accessible?
- f. Are trucks for washed clothes so constituted as not to drip on floor?
- g. Is soap and slippery material kept off floor?
- h. Are chlorination tanks (where used) and bleaching chemicals and solutions available only to skilled persons?
- i. Are all belts, gears, or rotating parts, arranged so as not to be exposed?
- j. Do electric irons have bull's eye signal and are they made for heavy duty use?
- k. Are there attachments to hold electric iron cords out of way?
- l. Are there hydraulic or pneumatic moistening sprays for ironers rather than rag and cup or blow (mouth) sprays?

#### 9. Central supply

- a. Are there interlocking doors on electrical dumb waiters?
- b. Are there recording temperature gauges for autoclaves?
- c. Are there approved standards of sterilizing technique?

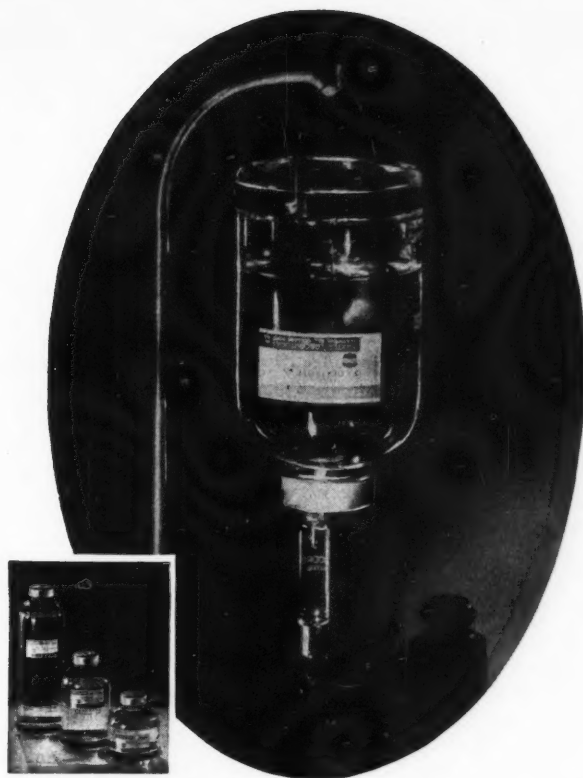
#### 10. Powerhouse and Associated Services

- a. Are adequate gauges and other safety apparatus provided?
- b. Are steel steps, ramps and floors as skid-proof as possible?
- c. Are lights continually burning in dark passage ways where rapid passage may have to be made?
- d. Are pipes, beams, bars protected to prevent head injuries?

#### Malpractice

Basically, all just claims result from accident or error, and only 10  
(Continued on page 44)





***Baxter's in Vacoliters can end the hectic rush  
of "emergency infusion"***

An intravenous infusion can be smooth, simple, certain . . . when you have Baxter's Dextrose and Saline Solutions in Vacoliters, because they are ready for immediate use. They are quickly available . . . waiting to do the delicate necessary tasks you ask of them.

Thus your emergencies become calm, orderly procedures, free from the breathless haste that can so easily mean irreparable error.

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PHARMACEUTICALS, SURGICAL INSTRUMENTS  
PHYSICIANS, HOSPITAL & LABORATORY SUPPLIES  
TORONTO MONTREAL CALGARY WINNIPEG

### Check List of Hazards

(Continued from page 42)

per cent of all accidents are actually unpreventable. The other 90 per cent are not truly accidents at all, but are entirely due to human failure, carelessness and incompetence.

The following safety measures are based on actual claims and their causes. Local or state laws may influence and govern certain conditions and should be considered. Violations of these safety measures are common and might easily produce a claim. Some duplication of items may be observed, but this list should be considered as an addition to the measures suggested under previous headings.

#### 1. Surgery

- a. Is the cabinet used for storage of sterile supplies, inscribed "sterile" on the outside?
- b. Are all empty cylinders of anaesthesia gases taped with adhesive, designating that the cylinder should not be relied upon for future service?
- c. Are there direct reading mercury thermometers in the exhaust lines of autoclaves to assure readings at the lowest operating temperatures?
- d. Is there an approved overhead water fill to the instrument and utensil sterilizer which will prevent syphonage back into the water supply? (The water waste fittings should have an open air gap broken fitting to prevent syphonage from the water waste into the sterilizer proper.)
- e. Is there a non-return and non-syphoning approved flushometer on bedpan sterilizers and all slop sinks? (The individual filters for each tank should have a trap to prevent raw water from entering into the sterile water tank. The waste connection should have an open air gap fitting.)
- f. Is the temperature of hot water available at the faucets throughout the building, except for kitchen and laundry supply, at a maximum of 120 degrees, thereby reducing the possibility of hot water burns?
- g. Is carbon tetrachloride used as a substitute for ether for cleaning and tape removal? (Ether is dangerous from explosion standpoint.)
- h. Are open or partially used cans of ether permitted to be stored

anywhere in the surgical department?

#### 2. X-ray

- a. As far as possible, are shock-proof and ray-proof units provided because of the known hazards incident to the use of other types of equipment?
- b. Is the release of x-ray films to patients prohibited?

#### 3. Dietary

- a. Are there thermometers in all refrigerators to assure accurate determination of the temperature and the maintenance of the food in proper state?

#### 4. Obstetrical

- a. Is the use of glass bottles for storage of waste ether prohibited? (Metal cans should be provided with tight fitting screw tops.)

#### 5. Laboratory

- a. Are vacuum breaks provided on rubber hose connections on faucets of the fixtures to prevent possible back syphonage?
- b. Are cages containing animals provided with suitable fly screens to prevent access of unauthorized persons?
- c. Animal cages should be kept locked.

#### 6. Nursing

- a. Are only approved electric pads permitted and then only when carefully supervised and routinely inspected? (It is suggested

that the switch be wired so as to provide low heat only.)

#### 7. Pharmacy

- a. Is there a method of checking the circumstances under which old prescriptions are filled or re-filled?
- b. Are keys to the pharmacy, laboratories, record rooms, supply rooms and other important departments limited to responsible persons? Are keys properly listed and signed out to each person? (Emergency keys should be provided in a central location and used only under careful supervision.)

#### 8. General

- a. Is the use of unlabelled bottles or damaged containers prohibited in all departments? (All medicines, narcotics or dangerous substances kept by nurses must be stored in locked cabinets, in well-lighted space or within nurses' stations which are constantly attended.)
- b. Are leaky, patched or worn hot water bags routinely discarded?
- c. Are medical records safe from inspection by patients and unauthorized individuals?
- d. Are oxygen tents and other oxygen therapy equipment set up and operated only by trained personnel?

### Regulations Respecting the Seeking of Medical Care Outside of Canada

In order to conserve foreign exchange for the purchase of essential war equipment, the Government has prohibited Canadians from spending money in the United States except for business, education or health, and, in each instance, permission must be secured from the Canadian authorities. This should not be construed as an unfriendly act; it merely conserves leaks in our foreign exchange so that more funds can be available for war purposes, in large part spent in the United States.

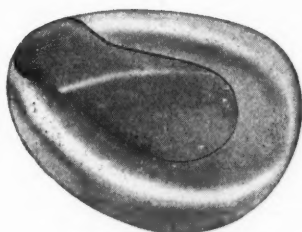
A large number of people annually leave Canada temporarily to seek medical treatment or for health reasons generally. On the assumption that the medical profession of Canada is capable of rendering all necessary care to Canadian citizens, the federal government has ruled that in future permission to leave Canada for these reasons will be granted only in rare and exceptional

circumstances; this is, only where the medical evidence as to the condition of the applicant proves conclusively that it is absolutely essential for him or her to leave Canada for such treatment.

New forms of application are being issued by the Foreign Exchange Control Board. The patient's application will be a separate document in which he will state his reasons for making application and name his doctor. The applicant's bank will then forward a medical report form to the doctor, to be forwarded to Ottawa directly. This permits the doctor to write frankly to Ottawa respecting the application. Nor is it necessary for him to make any recommendation, a former procedure which was often embarrassing. Federal officials, with advice from the medical officers of the Department of Pensions and National Health will interpret the factual data submitted.

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*Seamless triple-coated  
enameled Bed Pan*



*Pus Basin*

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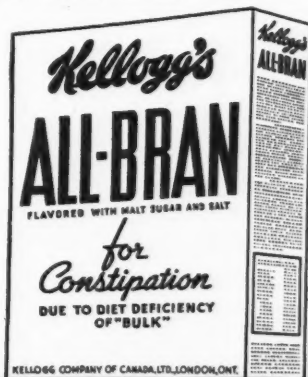
## Facts about a "BULK"-FORMING FOOD

In treating constipation, it is generally recognized there is a need for a food which, when used regularly, provides "bulk"-forming properties. KELLOGG'S ALL-BRAN . . . a crisp, ready-to-eat cereal . . . is such a food. (ALL-BRAN is also delicious in hot buttered muffins.) It is particularly adaptable to the treatment of constipation for two reasons:

1. ALL-BRAN is "bulk"-forming . . . not "bulk".
2. ALL-BRAN acts on the *contents* of the colon . . . not the colon itself.

Both of these characteristics have been proved by experiments.

**FREE:**—Reprints of two authoritative articles relative to bran and constipation, from the American Journal of Digestive Diseases and the Journal of the American Medical Association. Write Box A, Kellogg Company of Canada, Limited, London, Ontario.





## An Efficient Substitute for Ice Caps

*Note:—In response to an inquiry from one of our readers, respecting an item in our February, 1941, issue, Mr. R. E. Heerman, superintendent of the California Hospital in Los Angeles, has sent the following reply.*  
—Editor.

The system which we have been using for the past three years, is called the *Freeza-Bag* system developed in connection with this hospital by the Robertson Refrigeration Company, 1328-5th Avenue, San Diego, California. Before installing this system throughout the hospital we spent one year in experimenting with the manufacturer. We finally adopted the approved system in all the departments in the hospital with considerable saving of actual costs. The main items of cost eliminated were as follows:

1. Eliminating the manufacturing of ice, crushing, and distribution to twelve points in the hospital.
2. The elimination of twelve storage boxes operated from our brine system, and thus reducing the load on our brine and ammonia system.
3. The saving of about one-third of the time of nurses in filling and applying cold applications.
4. Practically the elimination of the replacement of the ordinary ice cap, most of wear and tear due to defects in caps, leakage, etc.

I do not know what the entire life of the rubber containers for the *Freeza-Bags* will be, but my conservative estimate at the present time is that over a period of years it will cut down the cost of replacement of rubber bags for this purpose 75%.

Conservatively estimating the cost of the installation against the first two items referred to above shows that it more than pays for itself during the first year. The system is developed in various sizes of throat and body bags made of pure gum rubber and green colour. After filling, the air is withdrawn and the bag is sealed by a special vulcanizing process, without the use of clips, caps, or metal parts of any kind. The solution will not deteriorate in the bag and will last for the life of the bag without breaking down. The bags are very flexible when frozen and can be molded to any portion of the body. The throat bag is only  $\frac{1}{2}$ " thick and fits the throat.

The bags are frozen in a cabinet with metal shelves closely woven with coils, maintaining a 10 degree temperature, producing a 20 degree bag. Mr. Robertson uses a standard Kelvinator  $\frac{1}{4}$  horse power unit, using Freon (F12) as a refrigerant. Each unit has room for 42 to 49 bags, depending upon the size, and the top shelf is used for three ice cube trays in case there is any necessity for ice cubes on the floor.

We have one of these units on each floor of the hospital. The nurse, therefore, in desiring a cold application goes to the refrigerator, picks out the proper size of bag, and places it in a muslin container, and makes the application. When the bag is returned it is taken out of the muslin container, dipped in a disinfectant solution, wiped and returned to the refrigerator shelf, and in a few hours it is again ready for service.

Our pathologist in making the original experiments gave us the following report:

"The contents of one bag were aspirated and subjected to certain tests. Total volume 460 cc., specific gravity 1.045, p.H. 5.2 (acid), boiling point 204 degrees F., freezing point 24 degrees F. The material was not inflammable and apparently has no irritating effect when placed in contact with the skin for a period of an hour. No bacteriological tests were made because it was not felt to be indicated. As I understand it, the contents are supposed to consist of a mixture of five parts water and one part C.P. glycerine. Glycerine is, of course, a hygroscopic agent, that is, it will tend to extract water from the tissues if left in contact for any length of time, and, if injected underneath the skin, it will produce sloughing and necrosis, but as applied to the surface would have no harmful effects.

"As regards temperatures which would cause injury to tissue it is generally acknowledged that sustained temperature of freezing, that is 32 degrees F., will produce harmful reactions upon the tissues, but a few minutes, that is 5 to 10 minutes at 32 degrees, would only cause blanching as a result of contraction of the vessels and a tingling sensation, but no permanent

damage. The tests carried out would indicate that although the temperature of the bag upon removing is 28 degrees F., it rises in a very short time up to above freezing point. I would feel that this would be perfectly safe."

The application of this solution in a rubber bag with a vulcanized process of sealing is a patented item.

After three years of use, we are confident that this is a "natural" as far as cold applications are concerned. All other systems have been based on freezing small quantities of water, or other solutions, that did not have the ability to absorb heat units. This system gives an efficient cold application lasting one-half to one hour longer than a similar size of ice cap with ice. It is more comfortable for the patient and can be put under a patient without discomfort. From experimenting, we have found the following pitfalls:

1. The shelves of the refrigerator must be made correctly in order to have flat contact with the rubber and special refrigeration to cool the liquid inside of the rubber bag.
2. Units must be provided according to demand. The unit cannot be overloaded as, if too many nurses take the bags out of the same unit, soon the bags will be started on a continuous circle of not being in the refrigerator the required amount of time for the starting temperature of 20 degrees. The bags soon after being taken out of the refrigerator units get up to 32 degrees, which, as you know, is the point where water takes the greatest amount of heat units.

We find in a general hospital such as ours that one unit with about 50 assorted bags is the proper size unit for a unit of 50 beds.

### Superintendent at Windsor, N.S., Resigns

Miss Anne Allan, R.N., has resigned because of ill health, from her post as superintendent of the Payzant Memorial Hospital, Windsor, N.S. Miss Margaret Dunbar, R.N., is acting superintendent.

### Tuberculosis Unit at Gaspé

The provincial government is making a \$135,000 grant to the Notre-Dame des Neiges Hospital in Gaspé, Que., for completion of construction and equipment of a tuberculosis wing to the hospital.



## *New in Efficiency* **FOOD CONVEYORS**

METAL CRAFT, electrically heated conveyors are MODERN . . . built to solve the problem of temperature-controlled, flavor-saving food distribution. It is the clean, practical way of conveying hot foods throughout the hospital . . . the ultimate choice for hospitals demanding the most modern standards of efficiency.

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## CRESCENT SURGICAL BLADES



# Colour Changes in Dyed Acetate Rayon Fabrics

By C. H. BAYLEY  
National Research Laboratories  
Ottawa

THE alteration in the shade of certain types of acetate rayon dyestuffs, has, in recent years, become a problem of considerable importance to the textile industry, the clothing trade and to the dry cleaner.

Usually the problem presents itself to the cleaner in some such way as follows: A blue dyed acetate rayon dress is cleaned in the usual way, and after cleaning and finishing shows a number of areas in which a reddish discoloration has taken place; a green acetate rayon dress, on cleaning and finishing, shows large areas in the skirt in which there has been considerable fading, the faded areas presenting a yellowish appearance. In such cases it is frequently impossible to convince the customer that the change in colour is no fault of the cleaner and frequently the cleaner pays a claim.

The purpose of this article is to briefly review the present state of our knowledge regarding this particular type of damage. The agencies responsible may be divided into two main classes, viz., (a) those consisting of liquid acidic compounds, e.g., perspiration, acidic deodorants, etc., which come into contact with the fabric as the result of some circumstance of use and (b) those consisting of gaseous products of combustion present in the atmosphere in which the fabric is used or stored. Whilst both of the above agencies may produce somewhat similar effects, it should be noted that the underlying causes of their action differ fundamentally from each other. They will, therefore, be discussed separately under the headings "acid reddening" and "gas fading", respectively.

## Acid Reddening

Acid reddening is a process somewhat similar to the reddening produced in a piece of blue litmus paper

—Reprinted from "Laundry and Dry Cleaning," *Journal of Canada*.

when subjected to the action of an acid solution. The chief difference is that, whereas the original blue colour of the litmus may be restored by treatment with an alkaline solution, such as ammonia, it is seldom possible to restore the original colour of the dyestuff in an acetate rayon fabric showing this type of damage.

Acid reddening frequently arises through contact with acid types of deodorants spilled on a dress or in the vicinity of the armpits. The damage may not become apparent until after cleaning and finishing, owing to the fact that traces of free acidity present in a fabric such as a dress are frequently not removed in the dry cleaning process, but remain in the fabric. Under the action of heat in the tumbling or finishing process, the damage develops. It will thus be seen that the extent to which the particular cleaning process employed results in the removal of water-soluble acidic stains will materially influence the prevalence of this type of damage. In the majority of cases the damage is already done when the fabric is received by the cleaner, although in the case of badly soiled garments, the overlying soil may render the contrasting shades less apparent prior to cleaning or conversely, more apparent after cleaning.

Acid reddening may result from contact with perspiration, and this type of under-arm discoloration is of common occurrence. In such cases, however, it may be pointed out that the effect of other constituents of perspiration and the effects of bacterial action occurring in perspiration undoubtedly play a part in producing the change in shade of the dyestuff.

## Gas Fading

The term "gas fading" is used to refer to the change in shade which, under certain conditions, takes place in dyed acetate rayon fabrics, especial-

ly during storage. This change is caused by the action of certain gaseous constituents of the atmosphere, notably oxides of nitrogen, produced during the combustion of coal gas. The early work on gas fading was carried out in England by Goodall<sup>(1)</sup> and by Rowe and Chamberlain<sup>(2)</sup>, who definitely proved that the constituents of combustion gases most effective in producing fading were oxides of nitrogen, but that other constituents such as sulphur dioxide and sulphur trioxide also played a part in producing this particular type of fading. The latter authors also showed that the phenomenon of gas fading was accompanied by chemical reaction involving the dyestuff and oxides of nitrogen.

In a recent article Cady<sup>(3)</sup> states that practically every direct dyeing blue, green and violet dyestuff, derived from anthraquinone and used on acetate rayon, is sensitive to gas fading, and that since practically all of the blue, green and violet dyestuffs used with acetate rayon are of the anthraquinone type, it follows that there are no acetate rayon dyestuffs available in these shades which do not show gas fading under certain conditions, whereas yellows, oranges and reds appear to show a much higher degree of resistance.

So important has the subject of gas fading become in the past three years that an intensive search is being made for ways and means of rendering dyestuffs resistant to this effect. Standard methods of test for determining whether a given piece of dyed acetate will undergo gas fading are being worked out, and in a recently described apparatus, the sample of fabric is hung in a specially constructed chamber through which pass the fumes from a burning gas burner.

- (1) Goodall, *J. Society Dyers and Colourists*, 51, 126 (1935).
- (2) Rowe and Chamberlain, *J. Society of Dyers and Colourists*, 53, 268 (1937).
- (3) Cady, *American Dyestuff Reporter*, 28, (No. 13), 333 (1939).



**TEMPTING  
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Patients who won't eat are less of a problem when you tempt their appetites with these light, flavoursome rennet custards. They appeal to the eye. And are as nourishing as they are delicious.

Easily and quickly made. Simply stir "JUNKET" RENNET POWDER into lukewarm milk and let stand undisturbed until set. About 10 minutes. Vanilla, Chocolate, Lemon, Orange, Raspberry, Maple.

If you prefer to flavor to taste, use "JUNKET" RENNET TABLETS.

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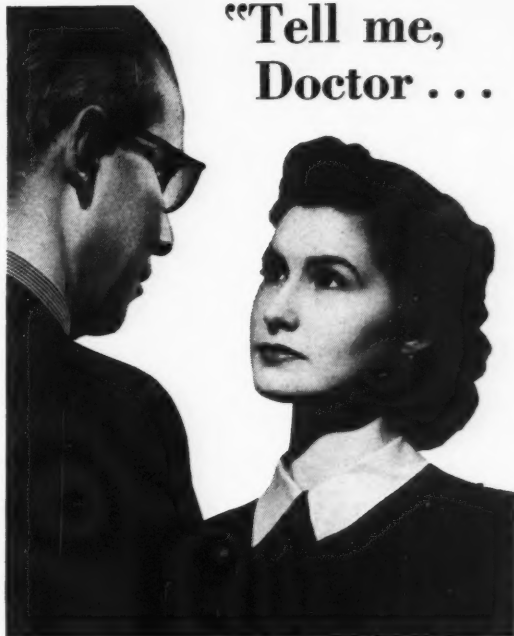
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Doctor . . .**



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**I**S there any antiseptic which can be used as safely in the home as in a hospital ward? Can you recommend an antiseptic which can be used as fearlessly for personal uses as for application to a scratch or insect bite?

Yes — you can unhesitatingly recommend 'DETTOL' for *all* home uses. This powerful, new British antiseptic destroys germs quickly, yet is non-poisonous and gentle to human tissue. You know its record of efficiency in the surgical and maternity wards of Canadian and British hospitals — prescribe it confidently for first aid, douching and general antiseptis.

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Reckitt & Colman (Canada) Ltd.,  
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**'DETTOL'**

(TRADE MARK)

**THE MODERN ANTISEPTIC**

## Manhood at Its Best



Courtesy Public Information.

The striking morale of the Canadian sailor is exemplified by the following letter which was written at Halifax by a twenty-year old seaman to his parents upon learning that his brother had been lost in H.M. C.S. *Margaree*.

"... If he is gone, let us trust he is one of few. It is possible that things could be in such a turmoil that no accurate or correct report or count can yet have been made. That has happened before.

"Do not grieve too much and do not hope too much. It cannot always happen to 'the other fellow', you know. Consider what a fine thing it is, if such it has been decreed, to lose a real man—one who has certainly done his bit. The Navy has given to Tom more than it could ever take away.

"He has gone through many of the big things in life in a very short period. He has been up against really big emotions; he has played his part in doing big things; he has

learned about men and character where one has the best opportunity to do so. Not the least is that the loves of his home, his parents, sisters and brother, have been realized both by him and by us as very powerful things indeed. Nor is it a small thing that, as I am finding out, in this life where one is so much by himself among so many, he looks a little more at himself and, if he has any stuff in him at all, he has the opportunity to properly point his compass."

The Royal Canadian Navy, 1908-1940.

### Refresher Course in Mental Hygiene at University of Toronto, May 14-17

A refresher course in mental hygiene is being given by the School of Nursing, University of Toronto, on May 14th-17th, at Toronto. The course, which is being given by outstanding Canadian authorities on this subject, will include observation visits and clinical teaching as well as lectures and round table discussions. Dr. C. M. Hincks, Director of the Canadian National Committee for Mental Hygiene, will deal with the scope, accomplishments and needs of the field as a whole. Lectures on the problems of childhood, adults and

parents will be given by Dr. W. E. Blatz, Professor of Psychology, University of Toronto and director of the St. George Nursery School of Toronto; Dr. J. D. M. Griffin, Associate Medical Director of the National Committee for Mental Hygiene; Dr. C. B. Farrar, Professor of Psychiatry, University of Toronto and director of the Toronto Psychiatric Hospital; and Dr. C. R. Myers, Assistant Professor of Psychology at the University of Toronto.

All registered nurses interested in mental hygiene are eligible for en-

rolment. The fee for the course is \$5.00 per student.

### Pasteurization Effective

The Department of Health for Ontario has reported that as a result of recent legislation 98% of all milk sold for fluid consumption is now being pasteurized and that there has been a marked reduction in diseases which may be milk borne. Typhoid fever has been reduced 50 per cent and undulant fever 45 per cent. At the time of introduction this legislation was strongly opposed by certain individuals, but this protest, which has been steadily decreasing, will have more difficulty now in overcoming definite factual evidence of the efficacy of pasteurization.

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• The Rt. Hon. Winston Churchill has rightly said that "workmen are soldiers with different weapons but the same courage." Farmers, factory hands, office workers, women in the home, are now doing their bit on the home front.

Although War Restrictions have drastically curtailed the production of "Wear-Ever" Aluminum Cooking Utensils, with the inevitable reduction in staffs and financial sacrifices, we look forward confidently to the day when all our workers will again be co-operating in supplying Canadian homes with

# "Wear-Ever"

**Aluminum Cooking Utensils**



## Canadian Hospital Council To Meet in Montreal in September

(Continued from page 31)

ture. Many of them are quite well equipped. Several people have suggested that where such temporary hospital would be proposed in a community where there is already a civilian hospital, such construction should take the form of a wing or annex to the civilian hospital. After the war and after the use of such buildings by veterans would be over, such accommodation could be utilized for civilian patients. A letter from Mr. Chester C. Wood of Toronto outlining a basis upon which such hospitals could be constructed and operated and finally turned over was read; with certain limitations as to applicability, the suggestions seemed to be sound. It was agreed that the president should prepare a brief for presentation to Ottawa stressing the importance of this matter from the viewpoint of national economy.

### Study Committee Reports

Preliminary reports from the chairmen of the various study committees indicate that these reports are well in hand and that the final drafts for presentation at the Montreal meeting in September should be of high order.

### The Canadian Hospital

The editorial policies now being followed by the editor were approved. Various suggestions, including the desirability of having more articles or synopses in French, were advanced and approved. The time has now come when, according to the agreement with the Canadian Hospital Publishing Company, the Council could purchase and take over in its entirety the management of THE CANADIAN HOSPITAL. In view of the present happy relationships with Mr. Edwards, the war situation and the fact that the option is a continuous one, it was agreed to take no action at the present time. The question will be brought up again at the September meeting. Mr. Edwards was congratulated upon the excellent work which he is doing as publisher of the Journal and on the many evidences of his desire to assist the Council on every possible occasion.

### Canadian Intern Board

The work of the Canadian Intern

Board during its second year was reviewed. The picture has been complicated somewhat by the increasing difficulty of obtaining sufficient interns to meet the needs of the hospitals. It was agreed that Dr. Anslev Seymour and Dr. Fred A. Logan of Toronto should again represent the Council on the Canadian Intern Board.

### Laboratory Technicians

Recognition of the Canadian Society of Laboratory Technologists as a registry by the Canadian Medical Association was noted as was also the publication of a basis of approval of schools for training of technicians in hospitals and public laboratories by a committee of pathologists and biochemists of the Canadian Medical Association. The syllabus of studies prepared by the Canadian Society of Laboratory Technologists was presented.

### Miss Anne MacLachlan

A formal resolution was passed expressing the deep regret of all members of the Executive Committee at the sudden death of Miss Anne MacLachlan, assistant secretary to the Council. Her resignation and death has resulted in a real loss to the work of the Council. A resolution of sympathy to Dr. Fred W. Routley, charter president of the

Council, was also passed, expressing the hope for his early recovery.

### Budget

A budget calling for an expenditure of \$4,690 for the year was approved. Anticipated revenue is estimated at \$4,675.00, provided all of the hospital associations maintain adequate contributions. This leaves a small deficit (\$15.00) which has been kept down to this size by arranging that one-half of Miss Frances Campbell's salary should be drawn from the Canadian Hospital journal account.

A number of other items relating to the daily work of the Council were considered. Several matters of general interest to the hospital field were referred to study committees for elaboration and inclusion in forthcoming reports. The meeting then adjourned.

### Miss Hollister Resigns at Orillia

Miss Dorothy Hollister, formerly assistant superintendent at the Orillia Soldiers' Memorial Hospital, Ontario, has been appointed superintendent of the Douglas Memorial Hospital at Fort Erie. She succeeds Mrs. Helen C. Jones, superintendent of the hospital since its opening a decade ago.

## COMING CONVENTIONS

- May 12—National Hospital Day.
- May 14-17—Refresher Course in Mental Hygiene, School of Nursing, University of Toronto.
- June 9-14—Institute on Hospital Accounting, Bloomington, Ind.
- June 9-14—Institute on Hospital Purchasing (A.H.A.), Baltimore.
- June 16-20—Catholic Hospital Association, Philadelphia, Pa.
- June 23-27—Canadian Medical Association, Winnipeg.
- June 25-26—Prairie Provinces Conference, C.H.A., St. Boniface.
- July 2-3—New Brunswick Hospital Association and Hospital Association of N.S. and P.E.I. (Joint Meeting) Halifax.
- Aug. 13-27—Institute on Hospital Administration, Chicago.
- Sept. 15-19—American Hospital Association, Atlantic City.
- September—Canadian Hospital Council, Montreal.
- Oct. 8-10—Ontario Hospital Association, Royal York Hotel, Toronto.

## Price Trends

	Yearly Average 1939 (On basis 1926 = 100)	January 1940	December 1940	January 1941
<b>Building and Construction</b>				
Materials .....	89.7	94.0	98.3	98.7
Consumers' Goods (Wholesale) .....	75.9	82.3	85.2	85.5
	(On basis 1935-1939 = 100)			
Cost of Living .....	101.5	103.8	108.0	108.3

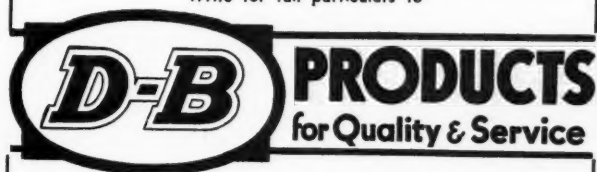
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MONTREAL, CANADA

## Institute Arranged on Hospital Accounting

The First Annual Institute on Hospital Accounting, conducted by the Council on Administrative Practice of the American Hospital Association, with the co-operation of the Indiana University, is being held in Bloomington, Indiana, June 9th to 14th.

The entire programme is based on "Hospital Accounting and Statistics" and every registrant is expected to have a copy of this textbook. Morning and afternoon sessions will include the presentation of papers and seminars for discussion. Three of the five evenings will be devoted to round table conferences. The lectures are to be given by such well known authorities as Graham L. Davis, James A. Hamilton, C. Rufus Rorem and Gladys Brandt.

The registration fee is \$10.00. Application blanks may be obtained from Stanley A. Pressler, Associate Director, Institute on Hospital Accounting, Indiana University, Bloomington, Indiana.

## First Annual Institute on Hospital Purchasing to be Held in Baltimore

The first annual Institute on Hospital Purchasing is being held at Johns Hopkins University, Baltimore, Maryland, June 9th to 14th, inclusive. The Institute will be conducted by the Council on Administrative Practice of the American Hospital Association, with the co-operation of Johns Hopkins University.

Sessions will be held both morning and afternoon and three evenings will be devoted to round table conferences. Among the speakers will be Arden E. Hardgrove, Chairman, Committee on Purchasing of the A.H.A., Edgar C. Hayhow, Warren Irwin, and members of the faculty of the university.

Anyone holding an administrative position in a hospital and having some purchasing responsibility is eligible. Registration fee is \$10.00 and dormitory accommodation and board is available if desired for \$20.00. Special accommodation will be provided for Catholic sisters upon request. Those desiring further information should write P. J. McMillin, Baltimore City Hospital.

\* \* \*

There is no difficulty in arranging funds for short trips to the United States, provided such is for definite educational reasons. It is necessary to have the usual passport, etc., and the bank manager can make arrangements giving one a permit to take the funds necessary for a short course such as this.

## Construction

The erection of a \$300,000, 125-bed hospital for Havre St. Pierre, Que., on the Lower North Shore is being studied by provincial authorities.

## Correction

We regret that a mistake was made in the account of the work of the Women's Hospital Aids Association given in the March issue. The St. Andrew's Hospital Aid, Midland, was credited with the contribution of \$1,000 to the War Activities Committee and note was made that the second quota for the same amount had almost been reached. This contribution to the War Activities Committee comes from the various aids throughout the province.

## Hospital Day

(Continued from page 30)

Each of Detroit's one thousand churches received circular literature and the majority made pulpit reference. The newspapers carried many articles and photographs. A "trailer"

was shown in a large number of movie theatres. The Michigan Hospital Services (then the Michigan Society for Group Hospitalization) sponsored a huge billboard on the Public Square (see photograph) where over 20,000 brochures outlining the history of hospitals were distributed on May 10th and 11th. All together between 15,000 and 20,000 people visited hospitals during the two-hour period on the Sunday afternoon. Hospital directors were delighted over the obvious stimulation of interest in hospital work.

## Radio Interference

(Continued from page 23)

not exceeding fifty dollars a day for violation of such may be imposed. However, no prosecution for causing interference shall be instituted unless and until the Minister certifies that an expenditure of less than \$50.00 would suppress the interference.

Copies of the Order-in-Council P.C. 252, of the circular S11-13-15 which explains the application of the regulations, and of circular S11-10-32 which gives specifications for shielding the room, may be obtained from Walter A. Rush, Controller of Radio, Department of Transport, Ottawa.

## TECHNICIAN—MALE

X-Ray Technician seeks position; fully qualified; excellent references. Box 163L. The Canadian Hospital, 57 Bloor St., W., Toronto.

## MATRON WANTED

Wanted.—Matron for hospital in Peace River country. Graduate staff, fully modern X-Ray and Laboratory technicians resident. For further particulars apply to Secretary-Treasurer, Grande Prairie Municipal Hospital, Grande Prairie, Alberta.

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